Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	T - State of Maryland / Dep State of Maryland / Dep Registrar Ce	artment of Health and N rtificate of Death		ene 2010	450
		•	Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
200	Physici /Medic		Thomas Roland Sansbury	ī	April 20	Day 2010	3:00 A M
1	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			17 Tracy's Lane	Tracy's Landing		Anne Arun	del
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) Coul	
	Director		218-44-3052 ¹ \mathbb{Y} M 2□ F 64 Yrs.		08-31-19	945 Mary	land
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Li	ocation			10d. Inside City Limits
	f sho	5					1 □ Yes 2 汉 No
	the N	Director	MD Anne Arunde1 10e. Street and Number	Tracy's Landing		g. Citizen of What Cou	ntry?
:	with		17 Tracy's Lane	20779		USA	
	ms 2	Funeral		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ameri	
Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. At the Maryland I file 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the invalidation of a context traumatic event, the invalidation of the results of the invalidation of the context traumatic event, the invalidation of the context traumatic event event traumatic event eve	by Fu	1 ☐ Never Married 2 ☑ Married Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1963–66	If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ▼ No Specify:	Rican, etc.)	Black, White, Specify:	^{etc.} nite
ŏ	2 hou	Completed	15. Decedent's Education 16a. Dece	edent's Usual Occupation	1	6b. Kind of Business/In	
215	hin 7 e. an "n	ed.	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)	ang l	JS Air Force	e and
7	erth.	5	12 Jet	Engine Mechanic		Government	Contractor
nd n	2 should be filled within and Mental Hygiene. is marked other than aumatic event, frem	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, M	aiden Surname)	
<u> X</u>	Ment Ment arked atice	၉	Samuel Roland Sansbury	Martha	Ann	Messick	
lar	2 sho and is m		1	ng Address (Street and Number or Ru		-	o Code)
٠ د د	and lealth m 27 her tu			Tracy's Lane, Trac			779
Ore	ges 1 t of F Mrite or ot		I Li Buriai 2 Mi Cremation 3 Li Removal from State 1	osition (Name of matory or other place)	Date 2	0c. Location - City or To	own, State
֟֞֞֝֟֝֟֝ <u>֚֚</u>	permit. Pages 1 and 2 si Department of Health an Important: If item 27 is a any Injury or other trau once.		4□Donation 5□Other (Specify) Metropol:	itan Crematory 4-2			
Bal	Departing Departing Important Incompany Incomp			2. Name and Address of Facility Ra			
	4B = 10 G		100	3325 Mt. Harmony L	· · ·		736 Approximate
		3 .	23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	1		st,	Interval Between Onset and Death
10.0	hysician /Medical		resulting in death)	astric carci	noma		3 months
12	Examiner		Due to (or as a consequence of)		,		
		P.	Sequentially list conditions, if any leading to in models. Due to for as a consequence of:				
	ured I Insit	Examiner	cause. Enter Underlying Cause (Disease or injury				
,	exect n and lai-tra	Exa	that initiated events c c Due to (or as a consequence of):				
8760,	ricate be executed physician and the burial-transit	dical	d				
89	mcar ig phy as th	edi					
Вох	attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	☐ Ectopic pregnancy		23d. Date of deliv	
. B	e dear	sicis	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month	Day Year
<u>Р</u>	at me I by th stache	h	9 Li Unknown				
Ś	ures mat me de signed by the a d be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the t	underlying cause given in Part I.		acco use contribute to	
Vital Records,	w requir s been s should	Completed			1 Ye	s 2□No 3□Fro	bably 4 🗋 Unknown
e G	has b	agr.			24a. Was ar autops	/ I prior to co	opsy findings available ompletion of cause of
<u> </u>	sician; The certificate h rector, page	5			perform 1 □ Yes 2	ned? death? 1 ☐ Yes	2 No
Vita Vita	ician Sertifi ector,	Be	25. Was case referred to medical examiner?		th (Check only one)	
ot	this aldir	은	1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpatie			nce 6 Other (Spec	ify)
u I	After After funer	io	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day, Year) 28b. Time of Injury (Month, Day, Year)	Work?	28d. Describe ho	w injury occurred	
Division of	death death ctor: / the	icat	2 Accident investigation 3 Suicide '6 Could not be 289 Place of Injury At home farm et		28f Location /Str	reet and Number or Rui	ral Poute Number
2	after after Dire	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	ioot, lactory, office	City or Town		ar regio rearras,
-	neral neral neral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place	, and due to the ca	ause(s) and manner as	stated.
2	To the hospital or Atlanding Priysician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atlanding physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or i and manner stated.	nvestigation, in my opinion, death occu	rred at the time, da	ate and place, and due	to the cause(s)
- #	Vithii To th	Me	29b. Signature and title of certifier	29c. License number	29	od. Date signed (Month	, Day, Year)
			1 - W front 1 / Nest)	011965		9/20/2	010
	IGL		30. Name and address of person who completed cause of death (item 23a) (Type	Print)	1	/	
Жh	, 94,		Joseph triend 1/6 Detense	they. Hugal	11, WM	21401	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1)		
	Registr	ar	APR 22 2010 Parent D.	Barks			

7/ 1	z her r	ν,		Type or Print State of Mary	in Black Ir	ndelible In	k. Ensu	ure All Cop	ies A	Are Legi	ible.	
4/	27/2010	, d	For State Registrar	State of Mary	-	tificate of I		ind Mentar		. No. 2	10	14502
	Physicia		Decedent's Name (First, Middle, Last Rodney	Marinus Marnius	Svedberg			2. Date of Month Apri		Day 201	Year	3. Time of Death 10:30 P M
-	Medi Examir		4a. Facility Name (if not institution, give s		Svedberg	4b. City, Town, o	r Location of			4c. County		110:30 1
-	<i></i>		6300 Antler Court			Dunki				Ca1	vert	
	Funeral Director		5. Social Security Number 559-48-7341 Usual Residence of Decedent	ZIM 2 DE	yrs. last birthday) 7 1 Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date of Montil (Montil		38	9. Birth Coun Nort	place (State or Foreign htry) h Dakota
	aryland a-f show fied at	Funeral Director	10a. State 10b. County		10c. City, Town or Location Dunkirk							10d. Inside City Limits 1 ☐ Yes 2.[X] No
	or 28 e noti	Dir	MD Calvert			10f. Zip Code	rĸ		100	g. Citizen of W	/hat Cour	
	s 23a nust b	nera	6300 Antler Court			20754				USA		_
	r item	Fur	11. Marital Status	12. Was Decedent Ever Armed Forces? 1 X Yes 2 ☐ No		Vas Decedent of H f Yes, specify Cuba	lispanic Origi an, Mexican,	in? (Specify Yes or Puerto Rican, etc.	No-		- Americ	can Indian, etc.
036	s after ral", o Exam	sq ps	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 M Yes 2 □ No If Yes, Give Year or Dates.196		☐ Yes 2 🕅 No	Specify:			Specify:	wł	nite
5-0	2 hour "natul edical	Completed	15. Decedent's Ed (Specify only highest grad	ucation	16a. Deced	lent's Usual Occup	during most o	of working	11	ib. Kind of Bu	siness In	dustry
21215-0036	within 7 giene. ner than t, the Ma		Elementary/Seconday (0-12)	College (1-4 or 5+) 4	life. Do	o NOT use retired) am/Manag	_		- 1			ernment of Defense
Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, Last) Arden	Sve	edberg		l	r's Name <i>(First, Mic</i> garet	idle, Mai			nald
Man	should and I		19a. Informant's Name/Relationship (Typ		I	-		or Rural Route Nu		ty or Town, St	ate, Zip (Code)
	and 2 Health tem 27		Joyce D. Svedberg		6300 Ob. Place of Dispo		ourt,	Dunkirk,		20754 c. Location -		Num State
E E	Page 1 lent of nt: If i		1 ☐ Burial 2 🏋 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, cren Metropoli	natory or other plac			1			
Baltimore,	permit. F Departm Importa any inju		21. Signature of Funeral Service License					Rausch				
8	9 9 E 6 9	72	Willow R	920				ny Lane,			20	0736
L	Chysician/ Medical	i F	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	a. Luws Due to (or as a cor	CANCE		ng, such as c	ardiac or respirato	ry arrest,		ő	Approximate Interval Between Onset and Death /// MONTHS
	Examiner		Sequentially list conditions,	bue to (or as a cor	isequerice oi).							
	xecuted n and al-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or implay that initiated events	Due to (or as a cor	nsequence of):						V.9	
0	e be exec ysician ar e burial-tı		resulting in death) Last	Due to (or as a cor	nsequence of):							
68760	rtificat ing ph e as th	/Mec	IF FEMALE:							1		
. Box (To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pr 1 Live Birth 2 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnand Other (specify)	су			23d. Date Mon		ery Day Year
P.O.	that the ned by a detail	y Pt	Part II. Other significant conditions co					23e. I	old tobac	co use contri	bute to th	ne cause of death?
ds,	v requires that is been signed k	ted	CHRONIE OBSTRO	LETIUE PUL	MONARY	DISEAS	38		X Yes	2 🗌 No	3 🗌 Pro	bably 4 Unknown
Division of Vital Records,	rsician: The law re certificate has be lirector, page 2 sh	omple						;	Was an autopsy performe	d 2 d	rior to co eath?	psy findings available mpletion of cause of 2 No
al F	ian: T artifica ctor, p	Be C	25. Was case referred to medical examiner?			26. PI	lace of Death	(Check only one)	Yes 2.7	No 1	□ res	2 🗆 110
Ξ	Physic this ce al dire	유	1 ☐ Yes 2 No 27. Manner of Death	1 Inpatient	2 ER/Outpatien		4 ⊔ Nur	sing Home 5 🕅)
28d. Describe how injury occurred 28d. Describe how injury occurred work? 28d. Describe how injury occurred work. 28d. Describe how injury occurred w											d	
Divis	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (Sp.	pecify)			City or	Town, S	itate)		Route Number,
	the Hosp nin 24 hou the Fune Tpleted fil	Medical	(Check 2 L Medical Examin	cian: To the best of my ker: On the basis of examine Practioner: To the best	nation and/or invest	igation, in my opinio	on, death occ	curred at the time, d	ate and p	lace, and due	to the car	use(s) and manner stated.
đ	To T		29b. Signature and title of certifier	uni_	MO	29c. Licenson D 4	e number 037	0	29d	Date signed	(Month,	Day, Year)
101	D 12+1		30. Name and address of person who co			rint)				1 1		
ak)	Sta	e.	Peter Wisniewski, 31. Date filed (Month, Day, Year)					O, Princ	e Fr	ederic	k, M	D 20678
	Registra		APR 2	32. Registra s S	un &	backer						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State RegistrarAmend#4c&10bperfuneralhome4/ Prificate of Peath Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 24 Stewart, Month 04 Physician/ 1240 AM George Edward Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Charles St. Mary's <u>Leonardtown</u> Mary's Hospita 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Funeral Hours 7-26-1952 Min. Maryland 215-64-6033 57 **Director** Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "not----" any injury or other twa-----10c. City, Town or Location 10a. State 10b. County Director St.Marv's 1 XYes 2 No Lexington Park MD Charles 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Funeral 20653 46121 Lucca Way 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married ģ 1 ☐ Yes 2 ➡No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Construction Worker 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alice Blackiston James E. Stewart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 46121 Lucca Way Lexington Park, MD 20653 Priscilla Gough/daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a, Method of Disposition Date cemetery, crematory or other place)
Charles Memorial 1 Burial 2 Cremation 3 Removal from State 4/1/2010Leonardtown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Briscoe-Tonic Funeral Home 2294 Old Washington Rd Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIO RESPIRATIONY Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner DATES RESPIRATORY HYPONIC Sequentially list could be if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): MILIARLY METASTAS or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical RENAL CELL Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 2 No 9 Unknown s after death.

I Director: After this certificate has been signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did topacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown Completed completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Mann of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a To the Funeral E Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar FON ARD TOWN

MALINI

hull

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State #20b
Registrar Amend per MVC 4/28/10 PCCH FIM Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 19 Day 2010 ${\stackrel{^{Month}}{ ext{APRIL}}}$ RALPH THOMPSON 3:45A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death PRINCE GEORGE HOSPITAL CHEVERLY PRINCE GEORGE Social Security Number 7. Age (In vrs. last birthday If Under 1 Year 6. Sex If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Funeral Months 1 🖾 M 2 🗆 F 8-07-1931 $\mathtt{NORTH}^{\mathtt{Country}}$ $\mathtt{CAROLINA}$ Director 243-44-4978 78 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD PRINCE GEORGE UPPER MARLBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3112 SQUIRE RD 20772 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ፟
 Yes 2 □ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 K Married Completed by Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE 9th ENTREPRENEUR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည LUCIAN WARD SR JESSIE THOMPSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GERALDINE THOMPSON/WIFE SQUIRE RD UPPER MARLBORO, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 04/27/2010 1X Burial 2 Cremation 3 Removal from State VETERANS CEMETERY -04-23-2010 | CHELTENHAM, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility JB JENKINS FUNERAL HOME 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each ne. Approximate rva Between Immediate Cause (Final and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) 23d. Date of delivery in the past 12 months? Day 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Tes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops 1 ☐ Yes 2 ☐ No Yes 2 N Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this d in by the funeral of 27. M er of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 atural ccident 3 Suicide injury 5 Pending 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29c. License number dress of person who completed cause of death (Item

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Vear rnesT Medical C)4 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Aug. 251935 Funeral 9. Birthplace (State or Foreign 1 **X** M 2 □ F Months Days Hours Min. 212-32-6538 74 Yrs Mary land Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Cecil Port Deposit 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9 Brenda Street 21904 U.S.A. 12. Was Decedent Ever in U.S 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: Completed 3 ☑ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Leo J. Umberly (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12)
Nine Years College (1-4 or 5+) White Marsh, Maryland Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Clarence G. Tyson Wilhemina Louise Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 520 Wheeler School Road, Whiteford, MD 21160 Paul Tyson (son) Baltimore, 20a. Method of Disposition

1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) ,20c, Location - City or Town, State West pinester Pennsylvania Date R.A.Ferris & Co., Ind. 04/23/10 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Name and Address of Facility ee A. Patterson & Son Funeral Home, P Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition SA Bacteremio Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed
24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and
it would be used filled in by the funeral director, page 2 should be detached for use as the burial-transit the attending physician and thed for use as the burial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year 2 No 1 ☐ Yes 2 ☐ Unknown 9 Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 🕱 No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🛛 Natural 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Within 2 To the Signature and title 164 940 5424

DHMH 17 Rev 7/2009

State

Registrar

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 14506 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2010 9:12 A M Robert Calvin Thomas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Atlantic General Hospital Berlin If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min 1 X M 2 □ F 91 3/28/1919 PΑ 187-03-1209 **Director** Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the "hedical Exeminat nust be notified at 1 ☐ Yes 2√☐ No Funeral Director Berlin MD Worcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12512 Deer Point Circle 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 1√1Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2√ No Specify. \$ Specify: white 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) n and Mental Hygiene. Finance Manager Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard W. Thomas ၉ Agnes Brady 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages t and 2 Department of Health Important: If item 27 any injury or other tra 1593 Teal Way, Woodbridge, VA 22191 27 William Thomas / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Cape Henlopen Crem. 4/23/2010 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Se lo Linnsee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 Approximate Interval Between Onset and Death 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immeriate Cause (Final disease or condition resulting in death) neogles Physician cars /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Physician/Medical Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 I Unknown 9 🗀 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 □ Yes THOMMS, ROBERT 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury accurred Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 72/10 and address of person who completed cause of death (Item 23a) (Type, Print) 1209 Courtal Highwa E.T 20+1 modelia luce 32. Pegistrar's Signatur 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

APR 23 2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 11:27 P **OLENE THOMAS** APRTL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death CIVISTA MEDICAL CENTER LA PLATA CHARLES . Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthdav. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** JAN. 14, Year 1927 Months Days Hours 1 🗆 M 2 👿 F 212-26-5670 83 MARYLAND Director Usual Residence of Decedent jiene. or than "natural", or items 23a or 28a-f shor the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND CHARLES NANJEMOY ¹X Yes 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8831 OLIVER PLACE 20662 UNITED STATES 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2X Married þ Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes Give Specify: BLACK 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 9TH GRADE (0-12) College (1-4 or 5+) HOUSEWIFE HOMEMAKER and Mental Hygie is marked other Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fi. f Health and Mental item 27 is marked ည NOBLE JACKSON JULIA MATTHEWS JACKSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEO THOMAS / HUSBAND 8831 OLIVER PLACE, NANJEMOY, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 permit. Page 1
Department of I
Important: If its
any injury or of 1 XBurial 2 Cremation 3 Removal from State MI. HOPE CHURCH CEMETERY APRIL 28,2010 NANJEMOY, MARYLAND 4 Donation 5 Other (Specify) ture of Funda Service (icense L HOME, P.A. ROAD, INDIAN HEAD, MARYLAND 20640 LYDIA C. THORNTON JOHNSON MOO583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Pnysician/ 245 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical certificate be Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No Yes the P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy , page , performed? Yes 2 N this certificate 1 🗌 Yes 2 🗌 No **Division of Vital** Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X** No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 1 🗌 Yes ပ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1X Natural 5 Pending injury 1 Yes 2 No M Accident Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physiciany To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 [] 3 [] Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse R actioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0033426 APRIL 22, 2010

BB | State Registrar

State pistrar 31. Date filed (Month, Day, Year) APR 2 3 2010

LARRY JENKINS, M.D. 111 LA GRANGE AVENUE (P.O. BOX 2665) LA PLATA, MARYLAND 20646
31. Date filed (Month, Day, Year)
32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10 Rum A. Sarke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ 20^{Day} 2010 real Genevieve Hodges Thomas 6:43 Pm M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomico Nursing Home Salisbury Wicomico If Under 1 Year If Under 24 Hrs. Social Security Number , Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 527-18-1870 1 🗆 M 2 🏝 F Hours Seloth Day 4ear 1923 A942ona 86 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Salisbury Wicomico 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 USA 921 Johnson Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. ò 1 Never Married 2 Married 1 Yes 2 XNC Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white Specify: 3 ₺ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) publishing secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Teresa Ochoa William Hodges 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 921 Johnson Road, Salisbury, MD 21804 Janet T. Veditz daughter Baltimore, N 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Maryland Veterans Cem 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State 4/28/10 Hurlock, MD 4 Donation 5 Other (Specify) # Funeral Service Licenses 22. Name and Address of Facility Thomas Funeral Home P.A. Signatur Cambridge, MD 700 Locust St., 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one caus-Immediate Cause (Final Ph sician/ disease or condition resulting in death) E Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 moviths?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Month Dav Pregnant at time of death 9 Unknown s been signed by the g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an has page 2 autopsy certificate Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be funeral director. 26. Place of Death (Pheck only one) ပု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 🗆 Yes 2 🗆 No injury Latural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahesha Thimmarayappa M.D 31. Date filed (Month, Day, Year) APR 23 State Registrar's Signatu Registrar DHMH 17 Rev 7/2009

29b. Signature and title of certifier

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29c. License number

910 Easternshore Dr Salisbury MD 21804

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 9:55 P M **Physician** 6 DSEPH /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Examiner** Anne Arundel Mandrin Hospice House Harwood Date of Birth (Month, Day, Y 12/31/ Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months 1 2 F 89 016-14-4067 Yrs MΑ Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f show Examiner must be redified at 1 □Yes XX No Director Anne Arundel Annapolis MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number within 72 hours after death with 21403 USA 3510 Rockway Ave. 'natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. XXYes 2 No If Yes, Give V 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1∐Yes 2XXXIo Specify. Specify. 2 If Yes, Give Year or Dates: ¥₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than 'any Injury or other traumatic event, It & Me Elementary/Secondary (0-12) College (1-4or 5+) Shoe Mfg. Superintendent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Pimental Joseph D. Tavares, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dennis Tavares Son Hanover, PA 17331 1035 Keith Dr. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition PBurial 2 ☐ Cremation 3 ☐ Removal from State St. Joseph Cemetery 4/20/2010 Hanover, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, 12 Ridgely Ave. Annapolis, MD 21401 21. Signature of Funeral Service Licensee 10 23a. Part 1. Enter the disease, of shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause — each line. Approximate Interval Between Onset and Death Immediate Cause (Final months **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of): Examine law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Records, P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Year Month Day P 5 Other (specify) signed by the a d be detached f ☐Yes 2 ☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 nknown nis certificate has been s director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 200 1 ☐ Yes 2 🗆 No 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1 Natural 1 □Yes 2 □No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29d. Date signed (Month, Day, Year)

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Wy1ie Month Elizabeth Gibbs 2010 03:00 P M Apri] Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Howard Brighton Gardens of Columbia Columbia Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F Days Months Hours Min. 06/10/1933 New York 122-30-1021 76 **Director** Usual Residence of Decedent 28a-f shov 10b. County "natural", or items 23a or 28a-f sho 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Mary1and Howard Ellicott City 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6325 Woodcrest Drive 21043 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?
1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ¥ Widowed 4 ☐ Divorced Specify: White Year or Dates ed other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N Registered Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Gibbs Dorothy Haslach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6325 Woodcrest Drive, Ellicott City, MD 21043 Peter D. Wylie/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Kalas Crematory 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 4-24-2010 Edgewater, Maryland 21. Signatur of F neral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. twee 6160 Oxon Hill Road, Oxon Hill, Maryland 20745 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failu k, or heart failure. List only one cause on each line. 3^{nset} EARS Physician ALZHEIMERS DISEASE) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or lingury that initiated events Due to (or as a consequence of) the attending physician and hed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available has prior to completion of cause of death?

1 Yes 2 No autopsy certificate 2 X No filled in by the funeral director, Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Assisted Other: 4 \(\triangle \) Nursing Home 5 \(\triangle \) Residence 6 \(\triangle \) Other (Specify) Living 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director; After it injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier соmpleted 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

31. Date filed (Month, Day, Year) APR 2 8 2010

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Harry Li, 8600 Snowden River Pkwy. #301, Columbia, Maryland 21045

29c. License number

D56531

29d. Date signed (Month, Day, Year)

April 22, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryl					2010	14511
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of L	Deam	Reg. 2. Date of Death	. No.	3. Time of Death
	Physicia	an	Catherine Mabel Wenner				Month	9, 2010	2:15 p M
,	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	vbrii i	4c. County of Death	
	Examin	er	Northampton Manor Health	Care	Frede	rick		Frederi	.ck
	Funeral		5. Social Security Number 6. Sex 7. Age (In)	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9 Rinth	nplace (State or Foreign untry)
	Director		223-60-7081 1 M 2 DXF 92	Yrs.	Months Days	riours iviir.	10/28/1		ginia
	2 2		Usual Residence of Decedent 10a. State 10b. County 10c	. City, Town or Lo	cation				10d. Inside City Limits
	sho	5							1 ☐ Yes 2 X No
	the N	ect	VA Loudoun I	Lovetts	7111E		100	. Citizen of What Co	untrv?
	with page	5	13166 Berlin Turnpike		20180	n		.S.A.	
	ma 2:	Funeral Director	11 Marital Status 12. Was Decedent Ever	in U.S. 13. V		lispanic Origin? (Span, Mexican, Puerto		14. Race - Amer	
0	or ite	Ē	Armed Forces? 1 Never Married 2 Married 1 Yes, Give	1	Yes 2 TrNo	Specify:	rican, etc.)	Black, White	
2-003c	e filed within 72 hours after death with the Maryland tylgiane. Office than "nature!", or itema 23a or 28a-f show other than "nature!", or itema 23a or 28a-f show ent, the Madical Examinar must be notified at	d by	3 ₩ Widowed 4 Divorced Year or Dates:					Specify:Whi	
<u> </u>	natu	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occupi kind of work done o DO NOT use retired	during most of work	ing 16	b. Kind of Business/	industry
7	withir	ם	Elementary/Secondary (0-12) College (1-4or 5+)	House		3/		Own Home	
70	filled Hygir Sther		17. Father's Name (First, Middle, Last)	nouse	SWITE	18. Mother's Name	e (First, Middle, Ma		
yland	id be ental ked c	To Be	Lloyd R. Virts			Elizab	eth Con	nor	
	2 should be and Mental is marked reumatic ev	-	19a. Informant's Name/Relationship (Type, Print)		-			City or Town, State, 2	
2	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. I the Marylar filem 21 is marked other than "naturel", or items 23a or 28a-f show other treumatic event, the Modical Examinar must be notified at		Nancy Orndorff-Daughter	13166	Berlin	_		ettsvill	
saitimore,	of He		20a. Method of Disposition 20 Burial 2 □ Cremation 3 □ Removal from State	Ob. Place of Dispo cemetery, cren	sition (Name of natory or other plac		Date 20	c. Location - City or	Town, State
Ĕ	Pages ment of tent: If it		4 □Donation 5 □ Other (Specify)	Mt. Oli				ovettsvi	
Sall Sall	permit. Pages 1 Department of H Importent: If Ite eny injury or ott		21. Signature of Funeral S rvice Licegsee	00 / 22	. Name and Addres	ss of Facility LC	udoun F	uneral C	Chapel
	403 e d		1 puly 19 emough we	dooth Do not ont	158_Cato	octin CR	SE Lo	esbura,	VA 20175 Approximate
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause in each line.						Interval Between Onset and Death
	Physician /Medical				lan ac	adent,	Nan	rost	years
	Examiner		Due to (or as a cor	nsequence or):					/
		ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a cor	nsequence of):					
	cuted	Examin	cause. Enter Underlying Cause Observed or houry that initiated events c						
o	be executed sicien and burial-transit		resulting in death) Last Due to (or as a cor	nsequence of):					
2/00		lcal	d						
ρ X	leath certificat attending phy I for use as th	Me	IF FEMALE: 23c. If yes, outcome of pr	20000000	·			204 8-4-44	
X Q Q	death c e attended for us	lan	in the past 12 months?	Fetal death 3	Ectopic pregnancy Other (specify)	4		23d. Date of del Month	Day Year
j	the de	Physician/Med	1 Yes 2 No 9 Unknown	or death 5	Other (specify)				
J.		y P	Part II. Other significant conditions contributing to death but no	t resulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Sp	The law requires that ite hes been signed b age 2 should be deta	ed by	Chonic atrial Abril	lation,	Core	nay	1 🗌 Yes	2 No 3 Pr	obably 4 Unknown
Hecord	aw require s been sig 2 should b	Completed	asteri disease Seve	of per	phon al	voscula	24a. Was an autopsy	24b. Were au	utopsy findings available completion of cause of
	sician: The law s certificete hes b lirector, page 2 s	E	distage				performe	ed2 death? No 1 ☐ Yes	
VITAI	ian: artifice ctor, p	Bec	25. Was case referred to medical examiner?			26. Place of Dear	th (Check only one))	
> 	<u>~ .⊎ 0</u>	ဦ	1 Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatien		4 Mursing He		ce 6 Other (Spe	cify)
		5	27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Yea	ar) 28b. Time of Injury	Wor		28d. Describe how	v injury occurred	
SIC	Attending it death.	cat	2 Accident investigation 3 Suicide 6 Could not be	At home form at		Yes 2□No	28f Location (Stre	et and Number or R	ural Route Number
DIVISION	after of A	Certification:	4 Homicide determined 28e. Place of Injury - building, etc. (S)	pecify)	eet, ractory, onice		City or Town,		ara. Fronto Frantos,
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely lilled in by the		29a. Certifier 1 Certifying Physician: To the best of my	y knowledge, death	h occurred at the tir	me, date and place,	and due to the cau	ise(s) and manner as	s stated.
	the Ho in 24 I the Fu	Medical	(Check only 2 Medical Examiner: On the basis of exa and manner stated.	mination and/or in					
	To the within 2 To the comple	Σ	29b. Signature and title of certifier		29c. Licens	se number	290	d. Date signed (Mont	m, vay, rear)
•			Kathleen W Stern	M	DE	32073	- '	4/19/20	10
	4		30. Name and address of person who completed cause of death	(Item 23a) (Type,		ave, E	Brunsw	ich Mil	, 217/6
	Sta	ate	31. Date filed (Month, Day Year) 32. Registrer's 3	Signature	/ .1	- 002)	
	Registi		APR 2 2 2010 - Ken	was B.	garre				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 25^{Day} Month Mae L. Wright 2010 Apr. 5:55a [™] Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3465 Pulaski Hwy. North East Ceci1 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Sept. 5, 1938 Hours Min. 1 □ M 2 □XF Director 219-34-4742 71 Yrs. MD Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho among hinty or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Ceci1 North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3465 Pulaski Hwy. 21901 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Maryland 21215-003 Specify: White 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 is and Mental Hygiene.
7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Isaac Pierce Stella McCall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fred Albert Wright/ Husband 3465 Pulaski Hwy. North East, MD 21901 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 4/29/2010 1 🗌 Burial 2 ី Cremation 3 🗌 Removal from State Rising Sun, MD 4 Donation 5 Other (Specify) R.T. Foard Funeral Home, P.A. 21. Signatur eral Servige License Name and Address of Facility
T. Foard Funeral Home, P.A
Î S. Queen St. Rising Sun, P.A. Sun. MD 21911 23a. Part 1 Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Oma disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of). it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events andtran Due to (or as a consequence of): resulting in death) Last burial-t attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Completed peeu Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 N death? this certificate 1 🗌 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After I completed filled in by the funera Natural 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. title of certifier 29b. Signature an 29c. License number 38. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 oria 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

10-03130 Maurice Waller

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 1 1 5 1 5 State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		Registrar Certificate of Death		i. No.							
Physicia	_	Decedent's Name (First, Middle,Last)	2. Date of Death		Time of Death						
/ledical Exami		Maurice Waller	Month April 22, 20	10	0622 hrs						
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death							
		543 Wilson Bridge Drive A-1 Oxon Hill		Prince George's							
		545 Wildelf Bridge Britan	Data of Bidh	(MM/DD/YYYY) 9. Birthpl	ace (State or						
Funeral	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	6. Date of Birth	Foreign	Wash DC						
Director	- 1	578-64-1030 1X M 2 F 60 Yrs. Months Days Hours Min.	12-1-	-1949 Countr	Wash, DC						
		Usual Residence of Decedent									
<u> </u>	ŀ	10a. State 10b. County 10c. City, Town or Location		10	d. Inside City Limits						
w any				1	Yes 2 No						
and sho	ᡖ	MD Prince George's Oxon Hill			4.5						
e Maryland or 28a-f show fied at once.	ਲ੍ਹੀ	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Country	?						
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must he notified at once.	Director	543 Wilson Bridge Dr. A1 20745		USA							
ith th 23a noti		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	acify Yes or No-	14. Race - American	Indian, Black.						
the w	9	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto F		White, etc.	101 - 565						
dear or it	Funeral	1 Yes 2 XNo									
after per	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: Bla										
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	윙	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w		16b. Kind of Business/Indu	ustry						
2 ho	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ea)								
dica	힐	2+ Metro Operator		Metro							
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21215-0036 buld be filed within 7 Mental Hygiene. marked other than	Be	Elwood Williams Lillie	e Walle	er	- O-d-\						
D 21 should and Mer 7 is man	유	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Relationship)	ural Route Numb	per, City or Town, State, Zi	p Code)						
MD d 2 sho lith and n 27 is		Lillie Waller/ Mother 1912 Valley Terrace									
re, ML s 1 and 2 s of Health a of item 27		20a. Method of Disposition 20b. Place of Disposition (Name of cametery,	Date	20c. Location - City or To-	wn, State						
Baltimore, MD 2 permit. Pages I and 2 shou Oepartment of Health and N Important: If item 27 is n injury or other traumatic		1 K Burial 2 Cremation 3 Removal from State crematory or other place)									
Pag Pag or o		4 Donation 5 Other Specify: Resurrection 4-29	<u>20101</u>	Clinton, I	MD						
Baltimore permit. Pages 1 Department of 1 Important: If injury or other		21 Signature of Funeral Service Licensee 22. Name and Address of Facility Brid	iscoe-T	Conic Fune:	ral Home						
CO STATE	A	General 2294 Old Washing	ton RI	Waldorf.							
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	respiratory arres	st, shock, or heart	Approximate Interval Between Onset and						
Medical		latitude. List only one cause on each many transition. Atherence learning Conditions on the Discoso									
Examiner	Examiner Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):										
	-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
	Ě	cause. Enter Underlying Cause									
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
uted Id Pansi		d.									
executed ian and ial - transit	Physician/Medical	UNPENDED AMENDED									
760, icate be expension the burial	ed			23d. Date of delivery							
8760, tificate be ng physici as the buri	Σ	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ncv	Month Day	Year						
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Box 68 le death certi the attendin	sic	1 Yes 2 No 9 Unknown 9 Unknown									
be de y the	٦h	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	pacco use contribute to the	cause of death?						
P.O. es that the igned by			1 Yes								
, P.(ires that signed be deti	g	chronic alcoholism									
ords w requi s been should	ete		24a. Was a autops		osy findings available apletion of cause of						
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Completed by		1 ✓ Yes 2	No 1 Yes	2 No						
tal Rection: The certificate ector, page	Be	25. Was case referred to medical 26.Place of Death (Check of examiner?									
Vita ysici his c	10 E	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing	g Home 5 F	Residence 6 🗸 Other: S	cene						
Of ing Ph		27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe h	ow injury occurred							
ndin th. th.	<u>.</u>	1 Natural 5 Pending (Molitif, Day, Year)									
SiO Atter dear ctor	cat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f Location (S	treet and Number or Rural	Route Number, City						
or A	\€	3 Suicide 6 Could not be	or Town, St		, ,						
pital ours	Certification:	4 Homicide									
Hos 24 h Fun etely		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	due to the cause	e(s) and manner as stated.							
Division of To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	t the time, date a	and place, and due to the t	ause(s)						
£ £ £ 8	₩.	29b. Signature and title of certifier 29c. License number		29d. Date signed (Month	n, Day, Year)						
		O.C.M.E. OCN	1E	April 23, 2010							
		Theodor M. hing JR., m. D.									
020		30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore	MD 21201								
Bb 3			J, WID 21201								
	tate										
Regis	trar	MINGOLVIV PRANCE B. MANGE									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2<u>010</u> Month Physician/ 11:58 PM 26 April Mary Columba Wetzel Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington 10518 Walters View Hagerstown Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth ecurity Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Months 217-12-1981 1 🗆 M 2 🔀 F 01172271924 86 MD Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 1 Yes 2 XNo Hagerstown MD Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21742 US 10518 Walters View Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. Armed Forces? þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White Completed 3 N Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Adeline (unk) Calandrelle Biagio Blaise Castellucci 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Deborah A. Carbaugh/Daughter 10518 Walters View, Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Cedar Lawn Mem Park 04/30/2010 Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licensee 305 N. Potomac Street, Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ prejunes Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) ____ Month in the past 12 months? Day Vear Pregnant at time of death Unknown g 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 2 No 4 Nursing Home * Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA ျ 1 Tes 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Matural Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Escrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) .E. Krutzera MD 13424 31. Date filed (Month, Day, Year) 32. Pogistrar's Signature State APR 28 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 18 Day 2010 Physician/ 12:24 A. M Fribley Williams Rosa Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Takoma Park Montgomery Washington Adventist Hospital 8. Date of Birth (Month, Day, Ye 9. Birthplace (State or Foreign If Under 24 Hrs Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 1931 **Funeral** Days 1 🗆 M 2 🕱 F Hours Min. Florida 79 579-40-3006 January Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b, County 10a. State Director 1X Yes 2 ☐ No District of Columbia Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **United States** Funeral 20012 625 Tewkesbury Place, N. W. permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 **Black** 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Washington Internal Elementary/Seconday (0-12) College (1-4 or 5+) Medical Laboratory Technician Medicine Group years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Elnora Thomas Joseph Fribley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 625 Tewkesbury Place, N.W.; Washington, D.C. 20012 Nathaniel Williams (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 3.2010 1 Burial 2 X Cremation 3 Removal from State Beltsville, Maryland Chesapeake Crematory, Inc. 4 ☐ Donation 5 ☐ Other (Specify) me and Address of Facility R. N. Horton Company Morticians, ignature of uneral Service Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Athero Sclerone Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Se Physician/Medical Þ Si Box 68760 attending IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death Other (specify) certificate has been signed by the irector, page 2 should be detached 9 X Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 🗌 Yes 26. Place of Death (Check only one) To Be 25. Was case referred to medica examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 - No 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) iniury work?
1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of

State Registrar

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14

MO

AGMED

Medical

29a. Certifier

29b. Signature and title of certifier

831 Univers 4

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

East

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrat Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** April 2010 ouise /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner acum Dorchester Street 90 5. Social Security Number 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. 1 M 2 F Months Hours 222-01-0803 Days 00 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or item any injury or other traumatic event. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 PYes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UM 61 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗹 No Specify 2 Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sewing esser 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah ward itchell ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta., Zip Code) 19a. Informant's Name/Relationship (Type. Print) Be MD.21613 ambridg 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Bethe 5 emetery Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address Facility 21. Signature of Funeral Service Licensee Henry Funeral Home, 1. 1. 5 io washingtow sto Can MD.21613 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CU /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy sate has been signed by the atte page 2 should be detached for i in the past 12 months?

1 Yes 2 00

9 Unknown Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 certificate 1 ☐Yes 2 ☐ No 1 TYes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Other: 4 \sum Nursing Home 1 ☐ Yes 2 ☐ 1000 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of De itt 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Accident 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar 29b. Signature and title of geriffer

Month, Day,

28

30. Name and address

GENT

person who completed cause of death (Item 23a) (Type, Print)

32

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 21 - State Amended 20a, 20b, Date&20c, WCHD, SLU, 426 10 Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month: 3. Time of Death Physician/ 2018 320 M Floyd Henry Williams, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5961364KS 410MIC If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral 1 🖾 M 2 🗆 F 5-30-1959 MD Country) Months Days Hours Min. 219-70-8829 Director 50 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10d. Inside City Limits 10c. City, Town or Location Director 1X Yes 2 No MD Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 305 Louise Avenue 21826 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc Completed by 1 Never Married 2 XMarried Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates. Navy 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Town of Elementary/Seconday (0-12) College (1-4 or 5+) Federalsburg Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Floyd H. Williams, Sr. Lenore F. Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) D'Anna Williams/Wife 305 Louise Ave, Fruitland, MD 21826 Baltimore, 20b. Place of Disposition (Name of L.L.C Directory Gremato teyplace) Federal Hill Cor 20a. Method of Disposition 20c. Location - City or Town, State Dover, DE 1 ☐ Perial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 010Federalsburg, MD ^{22.} Name and Address of Facility 917 W. Isabella St. Bennie Smith Funeral Home Salisbury, MD 21801 21 Signal to of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) CONGESTIVE HEART FAILURE Medical Due to (or as a consequence of) Examiner HYPERTENSIVE CARDIOMYOPATHY Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be executed VERY POOR LEFT VENTRICULAR EJECTION FRACTIONIS that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death Yes 2 No 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown CHRONIC ABDOMINAL PAIN Completed 24b. Were autopsy findings available prior to completion of cause of death? RENAL FAILURE 24a. Was an has autopsy performe After this certificate 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No To the Hospital or Attendi within 24 hours after death To the Funeral Director: A Investigation 6 Could not be Accident filled in by the I 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD,

32. Legistrar's Signature

6148

DALAL

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042522

Share Drive

APRIL 18, 2010

Salisbrug

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2010 04 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give streat and no **Examiner** orton 0 If Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, 07/10/ Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 1 □ M 2 F 220-26-8546 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show Important: if item 27 is marked other than "natural", or items 29a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2XNo Director ne 0 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 216 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No if Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No \$ Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Wor ampbell 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Datricia Saltimore, Place of Disposition cemetery, crematory 20b. Place 20c. Location - City of 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State Woods 4 Donation 5 Dother (Specify) 2010 21. Signature of Funeral Service Licensee Bennie Smith 298 Chestertown, MD Koute nau ammie Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Metastatic small cell cancer of lung **Physician** months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No certificate 2□ No 1 ☐ Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 2 No 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) Medical Certification: To this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral o 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? (Month, Day Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier R184659 of death (Item 23a) (Type, Print) ms Church Hill Road, Chestertown MD 21620 32. Regist State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #14 & 17, per Fh G903 5/7/10 TT
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 2010 1338 ADANE WOLDEMICHAEL Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 7504 Graylynn Drive Prince George's Lanham 8. Date of Birth (Month, Day, Ye March 31, Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 🛛 M 2 🗆 58 Months Days Hours Min. Country) Ethiopia 578-80-9680 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location Director Prince George's Lanham 1 ¥ Yes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Examiner must be 23a Funeral 20706 USA 7504 Graylynn Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc **Black** Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Ethiopian er than "natural", the Medical Exa 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) I Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Taxi Driver Private years Be 17. Father's Name (First, Middle, Last) Woldemichael Amdemariam 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H ဂ္ Amdemariam Woldemichael Abrheat Aman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 6415 9th Street, NW, Washington, DC Elizabeth Woldemichael - Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit, Page 1 Department of Important: If it any injury or o cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 04/09/2010 Gate of Heaven Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur unsuar S. vi icensee 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy Street, NW, Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ ASPHYXIATION BY HANGING disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury Due to (or as a consequence of): requires that the death certificate be executed and -tran that initiated events resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical Box 68760 as t attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Year Month Day Pregnant at time of death the q | Unknown 9 I Inknown P.0. by 1 signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DIABETES or Attending Physician: The law page 2 s autopsy certificate has 1 Yes 2 No Yes 2 V No rector, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 🗌 No မ 1 X Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of n 24 hours after death.

e Funeral Director: After the leted filled in by the funeral 28c. Injury at 28d. Describe how injury occurred Certificate: iniury work? 1 ☐ Yes 2 🛣 No 1 Natural 2 Accident 5 Pending Hung Himself in Closet Investigation 04/06/2010 1338 3 X Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7504 Graylynn Drive, Lanham, Maryland determined building, etc. (Specify) Home Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Set Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Single Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H0055927 April 8, 2010 ruder 30. Name and address of person who completed Lause of death (Item 23a) (Type, Print) MD, 3001 Hospital Drive, Cheverly, Maryland Salvador Sylvester, 32. Registr ♣'s Sign 31. Date filed (Month, Day, Year) State APR 1 6 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland	•	tment of Health and N	Mental Hygi	ene	11 500		
			Registrar 1. Despetent's Name (First, Middle, Last)	Certif	ficate of Death	Τ	Reg. No. 2 U U 1432U			
	Physicia Medic		PATTIE K YOU	1 NG		2. Date of Death	19 2070	3. Time of Death OY V9 M		
-	Examin	er	4a. Facility Name (If not institution, give street and number) * Anne Arundel Medical Center	4	b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arur	ndel		
	Funeral Director		5. Social Security Number 193–28–9830 6. Sex 1 \(\text{ \subseteq} \) 7. Age (In yrs. last \) 90		If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) Sept. 01	9. Birthp Count , 1919 North	lace (State or Foreign ry) Carolina		
	nd how at	'n	Usual Residence of Decedent 10a. State 10b. County 10c. City, T	own or Locati	ion		1	0d. Inside City Limits		
	Maryla 18a-f s	recto	MD Anne Arundel Anna	apolis		1 □ Yes 2 💆 N				
	ith the 23a or 2	Funeral Director	10e. Street and Number 1124 Riverboat Court		10f. Zip Code 21401	. 10	ng. Citizen of What Coun	try?		
	eath w	Fune	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was	s Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - America			
Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates.		es, specify Cuban, Mexican, Puerto Yes 2X No Specify:	Rican, etc.)	Black, White, e	ite		
15-0	72 hou "natu ledica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give kind	nt's Usual Occupation of of work done during most of work	ing 1	6b. Kind of Business Inc	dustry		
212	within giene. ier thau		Elementary/Seconday (0-12) College (1-4 or 5+)		NOT use retired) ry Worker		Knitting N	Mill		
and	be filed antal Hy ked ott c even	To Be	17. Father's Name (First, Middle, Last) Aloah Kornegay		18. Mother's Nam	e (First, Middle, Ma	aiden Surname)			
ary	hould and Me is marl			19b. Mailing /	Address (Street and Number or Rura		City or Town, State, Zip C	ode)		
<u>ئ</u>	and 2 s Health is		N. Dianne Maguire / Daughter		Riverboat Court A					
nor	age 1		1 X Burial 2 Cremation 3 V Remark from State Cem	e of Dispositi etery, cremati Tulke ' s	ion (Name of fory or other place) Apri S Cemetery 20	² 22,	Perry Twp., Berks Co.,	wn, State		
Baltimore,	permit. Page 1 a Department of F Important: If ite any injury or ot		21. Si nature o uneral Se, de la nisee		lame and Address of Facility	A Sever	Berks Co., ma Park Fur	PA Deral Home		
<u> </u>	99 = 89		Jameso Jarona	1 495	o Gov. Ritchie H	<u>wy, Sever</u>	ma Park, M	21146		
	nysician/	1	a. art 1. Inter the disease, of comblications that caused the death. I shock, or heart failure. List only one cause on each line.		τ,	Approximate Interval Between Onset and Death				
	Medical		disease of condition resulting in death) a. Due to (or as a consequence)		DEMENT			gear		
) Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequen	ce of):						
	outed nd ransit	kamir	cause. Enter Underlying Cause (Disease or injury that initiated events c	,			,			
	be exer	dical Examiner	resulting in death) Last Due to (or as a consequent	ce of):						
68760	ificate ng phys as the		IF FEMALE:					-		
Box 6	ath certificate be executed attending physician and for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 menths? 23c. If yes, outcome of pregnancy	eath 3 🗌 E	Ectopic pregnancy Other (specify)		23d. Date of deliver	ery Day Year		
Ö.	hat the de ed by the detached	hysi	1 Yes 2 No 4 Pregnant at time of dea 9 Unknown 9 Unknown		outer (specify)					
s, P.O.	gn ga	d by F	Part II. Other significant conditions contributing to death but not resulti	ng in the und	erlying cause given in Part I.	23e. Did toba	acco use contribute to th	e cause of death?		
Division of Vital Records,	w require is been si 2 should	Completed by				24a. Was an		osy findings available impletion of cause of		
Rec	rsician: The law is certificate has birector, page 2 s	Com				autopsy perform 1 🗆 Yes 2	ed? death?			
/ita	sician; certifii irector,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Inpatient 2 ER		26. Place of Death (Check					
of/	ng Phys ter this neral di	te: To	Impatent 2 Li En	b. Time of injury	28c. Injury at work?	ome 5 ☐ Resider 28d. Describe hov	nce 6 Other (Specify) v injury occurred)		
sion	I or Attending after death. Director: After I in by the funer	-1	Davida Alizaba							
Di <u>v</u> i	tal or A rs after al Direct ed in by	al Certificate:	4 Homicide determined 28e. Place of Injury - At home building, etc. (Specify)	, iaiii, sueet	, factory, office	City or Town,	eet and Number or Rural State)	noute Number,		
	To the Hospital or Attending Physiciam: within 24 hours after deals for the Funeral Director. After this certific completed filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check 2 Medical Examiner: On the basis of examination are only one) 3 Certifying Nurse Practioner: To the best of my knowledge.	nd/or investiga	ation, in my opinion, death occurred a	t the time, date and	place, and due to the cau	ise(s) and manner stated.		
	To the vithin To the comple	=	29b. Signature and title of certifier	3-,	29c. License number D 1436		ld. Pate signed (Month, L			
Ĵ	i e		30. Name and address of pelson with completed cause of death (Item 23	la) (Type, Prin		/	1 pw	17 -010		
U	HG.		MICHAR Jelate NA MO 445	DEFE	NSE HIGHWA	4 H MAG	MON END	(B)		
	Stat Registra		31. Date filed (Month, Day, Year) A PR 2 0 2010 32. Refistfar's Signature	1. 60	ake					

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		-	For State	State of M	laryland		ortment of Ho tificate of D			00	10	11501				
			Registrar 1. Decedent's Name (First, Middle	, Last)				eaur	2. Date of Dea	Reg. No.		3. Time of Death				
	Physicia Medic	al	WATER J	. Lf	W150	AK			Month,	Day 6	21/0					
	Examin	er	4a. Facility Name (If not institution, 201 Somerset Ba		14		4b. City, Town, or I	Burnie		4c. County	y of Death e Aru	nde1				
	Funeral Director		5. Social Security Number 076-30-8538		ge (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl 3/21/1		9. Birth Cour	place (State or Foreign				
			Usual Residence of Decedent		140 - O'b - T		4:				1.	10d. Inside City Limits				
	aryland a-f sho fied at	Director	10a. State 10b. County MD Anne	Arundel	10c. City, To		en Burnie					1 ☐ Yes 2🛣 No				
	the Ma or 28 se noti		10e. Street and Number				10f. Zip Code			10g. Citizen of		ntry?				
	th with ns 23a must b	Funeral	201 Somerset B			140.14		061	aif. Van au Na		SA					
36	after dear al", or iter xaminer	by	11. Marital Status 1 □ Never Married 2 □ Marria 3 ★₩Vidowed 4 □ Divorced	ied 12. Was Decedent Armed Forces? tick Yes, Give Year or Dates.	?	5 - "	Vas Decedent of His i Yes, specify Cuban ☐ Yes 🍇 No	, Mexican, Puerto	Rican, etc.)		ce - Americ ick, White, v: Wh					
2-0	Tear of Dates. 1905 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working 16b. Kind of Busi									Business In	dustry					
21215-0036	Elementary/Seconday (0-12) College (1-4 or 5+) life. DO NOT use retired) 12 Concre										rete					
م 2																
Maryland																
Mai	2 should lith and Me 27 is marl r traumati		19a. Informant's Name/Relations! Elizabeth Stein				ng Address (Street al Robby Ct.					Code)				
≒	of Heal of Heal fitem 2 rother		20a. Method of Disposition 1 Burial 2 □ Cremation	2 Pameual from Stat	20b. Plac	e of Dispo	sition (Name of natory or other place		Date	20c. Location		own, State				
Baltimore,	permit. Page Department of Important: If any injury or once.		4 Donation 5 Other (S	Specify)		land	Veterans	Cem 4/2	1/2010							
Bal	permit Depar Impor any in		21. Signature of Euneral Service L	ask		8	. Name and Address	lis Rd.	Gambril	1s, MD						
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final													
	hysician/ Medical		disease or condition resulting in death)	a. Sup Due to (Fras	Sr 5 a consequen	ice of):	2					VITYS				
F	Examiner	١	Sequentially list conditions,	b	ACMA		DECUB	1 TUS			<i>k</i>	MONTHS				
	ed ssit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as	a consequen	ice of):	200				- 3	UFARS				
	execut an and ial-trar		that initiated events resulting in death) Last	c. Due to (or as	a consequen		7010	1				7-0-0				
09	ate be executed physician and the burial-transit	dical		d	Lun	1000	ACPAL	Lyn	1 ptto	MA		YEARLS				
P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant	2 Fetal d at time of dea	eath 3	Ectopic pregnancy Other (specify)	/			ate of deliv	very Day Year				
О.	it the d by the stacher	Phys	9 Unknown Part II. Other significant condition	9 Unknown		ing in the u	inderlying cause give	en in Part I	23e Did t	obacco use con	atribute to t	the cause of death?				
ds, P.	quires the	ted by	Tartin Gulor significant contains						1 🗆			obably 4 🗆 Unknown				
Division of Vital Records,	The law rei ate has be oage 2 sho	Completed									. Were auto prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of 2 No				
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of Vi	y Physical this certal direction	e: _0	1 Yes 2 No 27. Manner of Death	1 ☐ Inpa 28a. Date of in		3b. Time of	1t 3 L1 DOA 28c. Injury	4 □ Nursing Ho at	-	dence 6 🗌 Ot how injury occur		ý)				
ono	ending eath. or: Afte the fun	ficat	1 Natural 5 Pendir 2 Accident Investi 3 Suicide 6 Could	gation	ay, Year)	injury	M 1 🗆	? Yes 2□No								
Divisi	cal or Att s after d al Directo ed in by t	Certificate:	4 Homicide determ	pined 28e. Place of Ir	njury - At home etc. <i>(Specify)</i>	e, farm, stre	eet, factory, office		28f. Location (City or Tox		ber or Rura	al Route Number,				
- :	ne Hospil in 24 hour ne Funera pleted fillk	Medical	(Check 2 Medical I	Physician: To the best of Examiner: On the basis of Nurse Practioner: To the	examination a	nd/or invest	tigation. in my opinio	 n. death occurred a 	t the time, date	and place, and d	ue to the ca	ause(s) and manner stated.				
	withi To to	_	29b. Signature and title of certifie	A A	in		29c. License	number $\mathcal{N}Y3X$		29d. Dafe sign	ed (Month,	19 W/U				
19	XHICH		Whame and address of person	who completed cause of	death (Item 20	3a) (Type, F	Print) EFEN	ne His	HWAI	ANNAP	our v	nonvol				
	Sta Registr		31. Date filed (Month, Day, Year) APR 2		trar's Signatur	1. 4	ak									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 25, 2010 Year Physician/ 7:45 AM Harry Blaine Zinn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Lusby 9225 Pardoe Road If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Months Days Hours (Month, Day, Year 01/14/194 Washington 216-40-5936 Director 67 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d, Inside City Limits 72 hours after death with the Maryland Director 1 ☐ Yes 2 🔀 No Lusby Maryland Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 9225 Pardoe Road 20657 Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 1 Married ¥ Yes 2 □ No Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ₩ No Specify Specify: White "natural", 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Banking & Finance Bank Executive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edwin Thompson Zinn Emma May Jacobs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie H. Zinn / Wife P.O. Box 178, Lusby, MD 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 D Burial 2 🔛 Cremation 3 D Removal from State 04/28/2010 4 Donation 5 Other (Specify) Alexandria, Virginia Metropolitan Crematory Signature of Funeral Service Licensee Rausch Funeral Home, P.A. 22. Name and Address of Facility P.O. Box 600, Lusby, MD 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. 10 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin tracore Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for 1 in the past 12 months? Month Dav Year 5 Other (specify) Ves 2 No signed by the a d be detached f g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 2-10 No 1 Yes 3 Probably 4 Unknown Completed 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page death? 1 🗆 Yes 2 🗆 No Yes after death.

Director: After this certific
I in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 2-X No ပ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? injury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide completed filled in by determined City or Town, State) Medical 1—Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of myknowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D33123 April 26, 2010

DHMH 17 Rev 7/2009

15

State Registrar 110 Hospital Rd., Suite 310, Prince Frederick, MD 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra s Signature

Jonathan Lowenthal, MD

31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend # 7, 17, 18, 19a, per Fh g903 5/20/10 TT

State of Maryland/Department of Health and Mental Hygiene

Amend Item 26 per verb., g903/5/10/2010dhb.

Reg. No. 2 | | | Reg. No. 20 1 - For State Registrar 14523 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day **Physician** 2:50AM 2010 RTIE B. 2 MA /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE AGNES Number 6. Sex SAINT HEACTIN Cave
7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Hours Min. | (Month, Day, 5. Social Security Number Birthplace (State or Foreign, Country) Funeral Year) 1 □ M 2 🖫 F 242-24-498 91 LORTH CREDINA Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show traumatic event, if a Medical Examinar must be notified at 1 Nes 2 No Director McL. BRLTIMORE 28a-f 10g. Citizen of What Country? 10e. Street and Number ŏ BAITIMORE NAT. PIKE
12. Was Decedent Ever in U.S. 13 L.S.A 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black White etc 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: Specify: BLACK 2 3 ☐ Widowed 4 Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, It a IM. Elementary/Secondary (0-12) College (1-4or 5+) ハルノムエモル 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Utikii0WN Informant's Name/Relationship (Type. Print) DAYGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Name of lace)

Name of lace)

Date

Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 107/2010 BALTIMORE, MARYLAND KING MEM PK CEME, 4 Donation 5 Other (Specify) 22. Name and Address of Facility DERLICK C. JONES FH P.A 21. Signature of Funeral Service Licensee PREK HEIGHTS AVE. BRIT, Md. 2/21 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final COMPLICATIONS OF PELVIC LUMBAR AND Physician FRACTURES disease or condition resulting in death) /Medical DAYS Due to (or as a consequence of) Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last NCHTON APPROVED BY MEDICAL DISEASE Due to (or as a consequence of) Examiner use as the burial-tran CERTIF Due to (or as a consequence of): physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Day Month Year 5 Other (specify) P.0. the 9 ☐ Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ ALZHEIMER'S DEMENTIA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed HYPER TENSION 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 certificate 1 ☐ Yes 2 No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Horsing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending ARIL 11, 2010 UNKNOWAM FELL DOWN STEPS 1 ☐ Yes 2 ☑ No 2 Accident investigation after death filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5 ! 10 BALTIMULE determined 4 Homicide City or Town, State) 5110 BALTIMORE WATIONAL PIKE # 305, BALTI HOME BALTIMURE To the Hospital within 24 hours a To the Funeral Completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DU051865 2010 MD CATON AVE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE 57 CURTIS BENRS HUSPITAL Chanlos 82. Registrar's Signature 31. Date filed (Month, Day, Year) State 1 0 2010 Registrar

THY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 12,20a-c,22 per fh g903 5-10-10 yet amend item 19a per fh g903 5-21-10 vt Certificate of Death

1- For amend item 19a per fh g903 5-21-10 vt Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death April 29^{bay} **Physician** 2010 Joseph Acanda 6:05 РМ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 120 Edenton Lane Caroline Denton | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Dec 10,) 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□ F Cub'a 77 146-30-2159 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location 28a-f show ral", or items 23a or 28a-f shov Director MD Caroline Denton 1 ☐ Yes 24 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21629 120 Edonton Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? unk. 1 Styles 2 No Korean If Yes, Give Year or Dates Conflict Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married cuban 1KIYes 2□No ğ Specify 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk truck driver other traumatic event, 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be is marked otl ဥ 19a Informant's Name/Relationship (Type. Print)
Lourdes
Lordis Acanda/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 8 44 Dalton Place; Edison, New Jersey 08817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date important: If it any Injury or o once. Final Journey 5-15-10 Woodbine, 22 Name and Address of Facility Board; 655 21. Signature of Euneral Service Licenses Name and Address of Facility Charisse, N., Woods F/S Director 23a. P. rt1. Enter the psease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st., or heart fillure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final **Physician** Conges disease or condition resulting in death) /Medical Due to (or as a conseque of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of) ii or Attending Physician: The law requires that the death certificate be executed after death.
Director: After this certificate has been signed by the attending physician and burial-tran Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Dav signed by the a 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 💢 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy diabete 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 NNo 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0047534 110 St Denton MD Z1629 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 920 Market Wafite Laki Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 6:40 AM OK /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE BALTIMORE CITY MEDICAL Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 07/27 Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 X F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Medical Examinar must be nutified at 1 ☐ Yes 2 No Baltimore Kandallstown MD Director permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-any Injury or other traumatic event, the Medical Experiment must be nutifi-10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number +130 21133 Windmill Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XÎVo Specify. Black Completed by Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PDP File Clerk 12th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John W. Epps Alice ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4130 Windmill Circle Husbund Wayne D. Randallstown MD 21133 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Owings Wills, MD 5/13/2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vallyhn C. Greene Funeral Se Nicos au Load Landaustown ND 21133 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart-failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** NDOMETRIAL CANCO /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely illied in by the funeral director, page 2 should be detached for use as the burial-transit completely illied in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à ificate has been siç r, page 2 should b 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No Division of Vital 1 ☐ Yes 2 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Naturai 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical bedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature ne fitte of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

xeche

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

Registr r's Signature

Lineur

Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14526 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 7, May 2010 4:10p Shirley Baxter /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 22 Vista Mobile Drive Dundalk If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 □ KF Director 73 231-44-1205 18 - 1937Va Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 3a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Baltimore Dundalk 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 22 Vista Mobile Drive 21222 USA item 27 is marked other than "natural", or items 23a other traumatic event, the Wodios Exercitor instit Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify White 2 3 X Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cashier Sales 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leo N. Plaskie Ethel Spoone ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21222 2707 Gray Manor Terrace Baltimore, Md Michael E. Baxter Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 5/8/2010 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Joseph N. Zannino Jr.FH 21. Signature of Funeral Service Licenses 263 S. Conkling St., Baltimore, MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Fina disease or condition resulting in death) Physician /Medical Due to (or a consequence of) Examine Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>\$</u> 3 Probably 4 Unknown 1 🗌 Yes No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 □No 1 □ Yes 1 Tyes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one, examiner' Other: 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) this 28a. Date of Injury 28b. Time of 27. Manuer of Death 28d. Describe how injury occurred After 28c. Injury at Work? (Month, Day, Year) Injury 1 Natural 5 Pending M s after death. investigation 1 ☐ Yes 2 ☐ No ✓ □ Accident the 1 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a

To the Funeral I the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely and manner stated. 29b. Signature and title of certifie ρ d cause of death (Item 23a) (Type, Print) ne and address of person 6585 NESST SITESIS Belfinge NO 2120 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G903,5/10/2010, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Bollin May 10.22 PM 2010 /Medical 4c. County of Death

Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Act. 433 andallstown DI Schmaer Drive, 225-21-250 Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) (Month, Day, Year) 03 14 1920 **Funeral** Min. Months Hours VA 90 Yrs. Director Usual Residence of Decedent 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, The Widinal Examinating the mother traumatic event, The Widinal Examination in the total part of the control of the cont MD Randallstown Baltimone 1 ☐ Yes 2 No **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21133 3801 Schnaper Drive Apb. 433 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Maryland 21215-0036 1 ☐Yes 2 No Specify: <u>م</u> Specify: Black 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 De artment of Health and Mental Hygiene. Im; ortant: if item 27 is marked other than "ne any injury or other traumant event, the Medicol." College (1-4or 5+) Elementary/Secondary (0-12) Mondawmin Travel Consultant 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bollin, Sr. Green trizabeth ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 Drive, Apt. 433 Randallstown, MD Bollin Schnaper 210 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gyvings Mills, MD Garrison Forest 13/2010 22. Name and Address of Facility Vaugeon C. Greene Funeral Sigs 8728 Liberty Road Pandall John MD 21133 21. Signature of Funeral Service Licensee augh 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he at 1 liure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Diabetes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Box 68760, Due to (or as a consequence of) Physician/Medical The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Month 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, vascular 1 Yes 2 No 3 Probably 4 Unknown failure 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autopsy performe Yes 2 1 □ Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 Accident 5 Pending 2 🗆 No within 24 hours after deau...

To the Funeral Director: / investigation 1 ☐ Yes 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) impleted cause of death (Item 23a) (Type, Print) security Blvd Baltimore 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Registrar
DHMH 17 Rev 1/2001

State

s Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Andrew Copeland Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day May 3, 2010 **Medical Examiner** 0115 hrs Copeland Andrew Α. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital **Baltimore City** N/A5. Social Security Number 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Min. Months Davs Hours Director 199\$ Waryland June 2, 215-39-0418 ₩ M 2 16 Usual Residence of Decedent any 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 No s 23a or 28a-f show 28a-f show N/A<u>Marylan</u>d Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21207 4804 Gwynn Oak Avenue 百 Funera 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White, etc. 2 X No Yes Black 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify è 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Forest Park Senior Elementary/Secondary (0-12) College (1-4 or 5+) Student 10th grade High 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Donj Bowden Andre Copeland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4804 Gwynn Oak Avenue Baltimore, MD 21207 19a. Informant's Name/Relationship (Type, Print) /Father Andre Copeland 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Woodlawn, Maryland 5/8/10 Woodlawn Cemetery Donation 5 Other Specify. 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licenses Reisterstown Rd Baltimore, MD 21215 5240 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line /Medical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of); Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical UNPENDED e attending physician for use as the burial -AMENDED Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery Bb. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown this certificate has been signed by the il director, page 2 should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 1 V Yes 2 No 28a. Date of Injury (Month, Day Year) May 3, 2010 After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot Natural 0030 hrs 5 Pending 1 Yes 2 V No 24 hours after death. Director: In by the f Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide or Town, State) 1500 West Fayette Street, Baltimore, Md 4 V Homicide (Specify) Local Street To the Fune completely f 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOME O.C.M.E. May 3, 2010 Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, gistrar's Signature State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Thomas Colgan 6:50AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Seasons Hospice at Northwest Hospital Randallstown If Under 1 Year If Under 24 Hrs Social Security Number 8. Date of Birth (Month, Day, Year) Aug 16, 1938 9. Birthplace (State or Foreign **Funeral** Min. 1 🔯 M 2 🗆 F Days Hours Maryland Director 219-26-6461 Aug Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Halethorpe 10e. Street and Number 23a or 10f. Zip Code 10g, Citizen of What Country? Funeral 21227 USA 2913 Michigan Avenue e filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 No 1955-Black, White, etc þ 1 Never Married 2 K Married 21215-0036 than "natural", or white 1 ☐ Yes 2 🔀 No Specify: If Yes Give Specify: 1958 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. General Motors assembly line Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Russell Joseph Colgan Catherine Gertude Funk it. Page 1 and 2 should represented them and Men prortant: If item 27 is market by injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2913 Michigan Avenue; Halethorpe, Maryland 21227 <u>Barbara Ann Colgan/spouse</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 \square Burial 2 \square Cremation 3 \square Removal from State cemetery, crematory or other place) 4 X Donation 5 Other (Specify) 21. Signature of Funeral Service Vicensee Rona Lu S Wada 22. Name and Address of Facility Board; 655 W. Baltimore Street Director Der Imp any Baltimore, Maryland 21201 nter the disease, comincations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate C use (Final disease or co ition resulting in death) Physician/ Lung (ancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Dian to for as a nonsequence on Exami attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month 4 Pregnant Pregnant at time of death Day Year 1 Yes 2 L 9 Unknown Yes 2 No After this certificate has been signed by the funeral director, page 2 should be detached P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Tes 2 🗌 No Be (Division of Vital 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Souther Specify Hospital Other: 2 **N**0 မှ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death e Hospital or Attending Pl n 24 hours after death. e Funeral Director: After ti Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 29c. License number MS RyapahseM.D DO057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N-S. Rujapakse, Mid. 2835 Smith Av, 5-235, Baltimore, MD. 21209-N.S. Rajapakse, MiD. 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

			Please 1	Type or Print in AMEND TTEM#TO State of Marylar	Black I	ndelible In	k Ensure /	WS Copie	s Are Leg	jible.			
		•	State Registrar	State of Ividiyia		rtificate of l		/leffical Fry	Reg. No 20	10	14531		
	Physicia Medi		1. Decedent's Name (First, Middle, Last)	DAMO	N			2. Date of De Month	Day	Year 2-010	3. Time of Death C924 A M		
	Examir		4a. Facility Name (if not institution, give st				r Location of Death ていかしR E		4c. County	of Death	1		
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bin (Month, Da	nplace (State or Foreign ntry)				
			Usual Residence of Decedent 10a. State 10b. County	10c, Ci	ty, Town or Lo	ocation		10570	3, 961		10d. Inside City Limits		
	Maryla 28a-f s otified	Director	Maryland N/A		altim	ore					1 🏿 Yes 2 🗆 No		
	n with the is 23a or	Funeral C	10e. Street and Number 115 Amity Stree	t		10f. Zip Code 21 2 2	23		10g. Citizen of USA	What Cou	untry?		
9800	e filed within 72 mours after death with the Maryland ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Fur	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates.		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No		ecify Yes or No- Rican, etc.)	14. Rad Bla Specify	14. Race - American Indian, Black, White, etc. Specify: Black			
Maryland 21215-0036	n 72 hou e. an "natı Medica	mplet	15. Decedent's Edu (Specify only highest grade Elementary/Seconday (0-12)	cation e completed) College (1-4 or 5+)	(Give	dent's Usual Occup kind of work done (OO NOT use retired)	during most of work	ing	16b. Kind of B	usiness Ir	ndustry		
d 21	The state of the s										ed		
ylan	The Father's Name (First, Middle, Maiden Surname) Polyton by the state of the stat												
	1 and 2 should be of Health and Men item 27 is marke other traumatic	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or To Rhonda Damon 924 N. Luzerne Ave Baltimore,									^{Code)} 21205 land		
nore	Page 1 ar nent of He ant; If iten ıry or oth		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ R	emoval from State	emetery, cre	osition (Name of matory or other place	ce)	Date /10 T	20c. Location				
Baltimore,	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mt. Zion Cemetery 5/5/10 Lansdown 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Chatman—Harris F 5240 Reisterstown Rd Baltimor												
		4	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	cations that caused the deat						le,r	Approximate Interval Between		
~	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)		moin	stis Jiro	reca P.	reume	nia		Onset and Death		
	Examiner	-e-	Sequentially list conditions, b	HIV	dix	ease.				_			
	executed ian and irial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a consequence	uence of):					V			
	ate be execut physician and the burial-tra	<u> </u>	<u></u>										
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ic. If yes, outcome of pregna 1 Live Birth 2 Fett 4 Pregnant at time of a 9 Unknown	aldeath 3 [☐ Ectopic pregnand☐ Other (specify)	cy		- 1	ate of deliv	very Day Year		
s, P.O	res thet t signer b	वि	Part II. Other significant conditions conf Cacheyia		ulting in the		ven in Part I.			_	the cause of death?		
cord	aw requias been 2 sh ul	Completed		-			***************************************	24a. Was	an 24b.	Were auto	opsy findings available ompletion of cause of		
a Re	in: The lificate h		25. Was case referred to medical			26 PI	ace of Death (Chec	1 🗆 Yes	ormed? 2 A No	death?	2 No		
✓ita	hysicia this cert	To Be	1 La res 2 La, No	spital: 1 🔼 inpatient 2 🗆		nt 3 🗆 DOA	er	, ,	dence 6 🗆 Oth	er (Specif	iy)		
o uc	ath. r: After t re funera	Certificate:	27. Manner of Death 1 A Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	work		28d. Describe I	now injury occurr	ed			
Division of Vital Records, P.O.	ital or Atte urs after de ral Directo led in by th		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		eet, factory, office		28f. Location (3 City or Tov	Street and Numb vn, State)	er or Rura	al Route Number,		
	ne Hosp in 24 hou ne Funel pleted fii	Medical	(Check 2 Medical Examine	ian: To the best of my know r: On the basis of examination Practioner: To the best of m	n and/or inves	tigation, in my opinio	on, death occurred a	the time, date a	and place, and du	e to the ca	ause(s) and manner stated.		
	Vith To the		29b. Signature and title of certifier	GANTI, SHI	A. M	29c. License	69 49°	2	29d. Date signer		Day, Year), 2010		
	11		30. Name and address of person who con	npleted cause of death (Item	23a) (Type, I	Print\				1-11	, 20,0		
	Star		SHIVA K OIAN 31. Date filed (Month, Day, Year)	32. Registrar's Signa			1 MORE	/ (*/3) ;	420)				
	Registra	ar	MAY 1 0 2010 4	rous d. L	Parke								

10-03430
Dennis Diggs

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2 1 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar			Certific	ate of	Death			R	eg. No.				
Physici	an/	Decedent's Name (First, Middle	le,Last)						2.	Date of Dea	th	Vaar	\Box	3. Time of Death	
/ledical Exami	iner	Dennis Joh	n Diggs	, Sr.						Month May 3, 20	Day 10	Year		2045 hrs	
		4a. Facility Name (if not institutio	on, give street and n	umber)		4	b. City, Town, or	Location of	f Death		40	. County of	Death		
		1313 W. Lafayette Av	enue				Baltimore					N/	/ A		
Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last bir	thday)	If Under 1 Year		r 24Hrs.	8. Date of Bi	rth (MM/	DD/YYYY)	9. Birti	hplace (State or Fo	oreign
Director		218-60-4797	1 M 2 F	5	7	Yrs.	Months Days	Hours	Min.	May 3	23,	1952	Mar	yland	
		Usual Residence of Decedent									-				
any		10a. State 10b. County									10d. Inside City Li	imits			
≹ ,,	L	Maryland N/	Α		E	Balti	more						ı	1 X Yes 2	No
Maryland 28a-f show 1 at once.	5	10e. Street and Number					10f. Zip Code			11	0a. Citi	zen of Wha	t Coun	itry?	
e Ma or 28	Director	1313 W. Laf	avette	Ave			212	17			US			-,.	
eath with the Maryland items 23a or 28a-f shc ist be notified at once		11. Marital Status	12. Was De		a in II C	12 Wes	Decedent of His	anda Odel	-2 / 6			44 D	A	In the Disale	
ath w	Funeral		arried Armed F	Forces?			Decedent of His s, specify Cuban					White,	etc.	can Indian, Black,	
a de	F		1 Yes orced If Yes, Give Ye	2 🔀	No		Yes 2 No					Specify: B	lac	ck	
s aft	þ	15. Decedent's Education (Spec	or Dates:		od\ 1160		s Usual Occupati		ind of word	l. dono		Specify: (ind of Busi			
hour Exar	Completed	Elementary/Secondary (0-12)		(1-4 or 5+)	.ea) 16a.		st of working life.							, 	
36 in 72 fical	ple		College	(1~4 UF 5+)	Pı	cint	ing Ass	ista	int		Fo	rm S	er	vice Pri	int
with with her t	om	11th grade 17. Father's Name (First, Middle,	l act)		*					irst, Middle, I		g Co	•		
fled Hyg		John Diggs	Last)					Albe	erta	Garn	er	Surname)			
21215-0036 muld be filed within 77 Mental Hygiene. marked other than event, the Medical	b Be	19a. Informant's Name/Relations	hin (Typo Print)		10	h Mailing	Addross (Steen	and Niverb	had ad Duw	al Davida Nive		h. as Tarra	Chata	75- Cada)	
Shou shou and N	7	Natthel Diggs		er	12.0	641	Address (Street Gatehou	ise D	0r.	Balti	mor	e,MD	State,	忙 Ž 69 7°	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shi injury or other traumatic event, the Medisal Examiner must be notified at once		20a. Method of Disposition												Town, State	
S 1 g		1 X Burial 2 Cremation	3 Removal f	rom State	cremai	tory or other	ion (Name of cerr er place) Memoria	1 0	3/8/ [~]	10				aryland	
Pag Pag nent sant:		4 Donation 5 Other Sp	pecify:		Arbu								-		
Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Signature of Funeral Service	Licens			22. Na	me and Address O Reist	of Facility	Cha	tman _p	Har	ThSr	-Eu	MBrl Ho	me
E. E. D. B. CE	1	- Killing	Hara											21215	
Physician		23a. Part I Enter the disease, or failure. List only one cause	complications that on each line.	caused the	death. Do n	ot enter the	mode of dying,	such as car	rdiac or re	spiratory arr	est, sho	ck, or hear	t	Approximate Inte Between Onset	
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):											Death	.	
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	_	Sequentially list conditions,	b												
	miner	If any leading to inmediate cause. Enter Underlying Cause	Due to (bries)	a consecue	nca of):										
	(7)	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a conseque	nce of):						_		-		
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	Jul 1	23b. Was decedent pregnant in th past 12 months?					I death 3	Ectopic p	pregnancy	,		Month	•	ay Year	
Box 68 e death certil the attending ed for use as	ici			nant at time	of death	5 Othe	er (Specify)								
Box 687 he death certification of the attending properties as the for use as the form of the forethe form of the	Physiciar		g Unkn												
P.O.	by P	Part II. Other significant conditi	ions contributing t	to death but	not resultin	g in the un	derlying cause gi	ven in Part	t I.			_		he cause of death?	
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Recol The law cate has	Ĕ									perfor	rmed? 2 ✔ No	dea	ath?		
tal Rection: The certificate ector, page		25. Was case referred to medical					26 Place	of Death (C	Check only		-	' '	Yes	s 2 No	
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use at	Be	examiner?	Hospital:	Inpatient	2 ER/O	utpatient		Othor:	Nursing H		Reside	nce 6 🗸	Other:	Scene	
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	ertificatio	deter	d not be Specify		At nome, is	ann, street,	ractory, office bu	maing, etc.	. 20	or Town, S		na Number	or Rura	al Route Number, (ال
Di ospital hours a aneral J	O	4 Homicide	(0,000,0)												
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
To t with To t	ledi	29b. Signature and title of certifier	and manner s	stated.			29c. License	_							
	Σ	29b. Signature and title of certified										_		th, Day, Year)	
		Yangelet outhe	all, MD			O.C.M.E. May 4, 2010									
AV		30. Name and address of person					D - 0:	D		0460:					
1,		Pamela E. Southall, M		Maria I		r 111	Penn Street,	Baltimo	ore, MD	21201					
St Regist	ate	31. Date filed (Month, Day, Year)	2010 32.8	gistrar's Si	gnature	1	at 1								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Marlene 1914 **Physician** 03 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner n/a **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Nov.9,1946 215-46-5362 MD Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show Examiner must be notified at 1 Yes 2 No Director MD n/a Baltimore Pages 1 and 2 should be filed within 72 hours after death with the nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code Lafayette Ave. 2016 E. 21213 Funeral USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Black 2 3 Widowed 4 Divorced Completed al Hygiene. d other than "natura went, the Medical E 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 2yrs Nursing Assistant Eutaw NursingFacility 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jerome Blue Florence Tibbs 2 or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joseph Downs/Husband 2016 E. Lafayette Ave. Balto. Md. 21213 permit. Pages 1 and Department of Health Important: If item 27 any injury or other to once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 XCremation 3 Removal from State Balto. Md 4 Donation 5 Other GreenMountCrematoryMay7,2010 21. Si nature of Funeral Service 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 F. PRESTON ST. BALTO. MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** YEAR CORONARY ARTERY DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avants UNCONTROLLED BIABETES Examiner Due to (or as a consequence of) HYPER TENSION that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 - Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 \ 0 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one, 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 27 Manner of Death Certification: 1 Natural 5 Pending investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p Hospital

2

Registrar

ANGIEL CHAN 31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

29a. Certifie

(check only

Medical

32. Registrar's Signature

park

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

MAY 4, 2010

600 North Wolfe St, Baltimore, MD, 21287

WAY 1 0 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 **Physician** 3:44PM В. Eline May 6 James /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore <u> Greater Baltimore Medical Center Towson</u> 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☑ M 2 ☐ F Director 218-32-8021 74 Oct 7, 1935 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examinat must be autified at 1 ☐ Yes 2 ☑ No Director Baltimore Reisterstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12610 Timber Grove Road 21136 U.S.A. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ⊒Yes 2 □ No If Yes, Give Year or Dates: 59-61 1 ☐ Never Married 2 🙀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 years Funeral Director Funeral Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Edwin Eline Mary Bevard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet B. Eline 12610 Timber Grove Road Reisterstown, MD 21136 Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All Saints Cemetery 5/11/10 Reisterstown, MD 22. Name and Address of Facility 11824 Reisterstown Road 21. Signature of Juneral Service License ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart latture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MON /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it are underly to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐No 9 ☐ Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 ☐ Yes 2 ☐ No 2 IZ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospita.

Within 24 hours after deatn.

To the Funeral Director: Aft

....nletely filled in by the fur 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Registrar

1071

29b. Signature and title of certifier.

· Cuntina Suiam MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CYNTMIA SURIAND MD 6701 N-CHARLES ST BALSIMANE MD 21207

32. Registra s Signa ure

29c. License number

D0057347

29d. Date signed (Month, Day, Year)

France, Crystal

DHMH 17 Rev 7/2009

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		•	For State Registrar		State	or iviary	land / Dep Ce	arumenu rtificate			and ivi	епіаі пу	Reg. N	001	0	4535
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	Examin	er	4a. Facilitý Name (if Baltimor		n, give street and nur Shington 1		cl Cente	4b. City, To	own, or		of Death	J		c. County of		undel
	Funeral Director		5. Social Security No. 553–56–63.		6. Sex 1 □ M 2 KF	7. Age (In)	rs. last birthday) Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs.	8. Date of Bid (Month, Date) 05-23-	rth			e (State or Foreign FL
	show lat	or	Usual Residence of 10a. State	10b. County			. City, Town or Lo								10d.	Inside City Limits
	r 28a-f	Direct	MD 10e. Street and Nun		Arundel		Glen Bur	nie 10f. Zip (code.				100 (Citizen of Wh		1 ☐ Yes 2 🛣 No
	ns 23a c must be	Funeral Director	827 Bent					210	61				US		at oodinity:	
9800	permit. Fage 1 and 2 should be liled within 72 hours after death with the Maryland agardnent of Health and Mentilled Hyglene. Inportant: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	11. Marital Status1 ☐ Never Marr3 ☐ Widowed		If Von Cit	orces? 2 No ve		Was Decede If Yes, specif 1 Yes 2	y Cuba	ın, Mexicar	n, Puerto F	cify Yes or No- Rican, etc.)		Black,	American Ir White, etc. White	ndian,
21215-0036	an "nati Medica	mplet	(Spe	cify only high	nt's Education est grade completed College (*		i (Give	edent's Usual kind of work DO NOT use r	done c	during mos	t of workin	g	16b.	Kind of Busi	ness Industi	ry
d 21	Hygiene Hygiene other th ent, the	Be Co	12 17. Father's Name (i				Pre	School	Te			(First Middle		lucatio	on	
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Mi												viaiden Surname)				
, Mar	id z snot salth and n 27 is n er traum		19a. Informant's Na Edgar L.		hip <i>(Type, Print)</i> e , Jr. /]	Husbar						Route Numbe en Buri				*)
nore	age lar		20a. Method of Disp 1 Burial 2 4 Donation	Cremation	3 Removal from		Db. Place of Disp cemetery, cre V. Arund	matoni ar oth	or nlan			ate /2010		Location - Ci	-	State
Baltimore,	Departm Departm Importar any injur once.		21. Signature of Fu									and Ci	rema	tion S	Servic	æ, PA
	nysician/ Medical Examiner	ər	23a. Part 1. Enter t shock, or heal Immediate Cause (disease or condition resulting in death) Sequentially list confirm the first time.	rt failure, List (Final on	b. ———	y o Ca or as a con	death. Do not en	ter the mode	of dying	g, such as	cardiac or	respiratory a	rrest,	<u> </u>	Ap Inte	proximate erval Between set and Death
68760 ÷	ate be executed physician and the burial-transit	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last c														
. Box 68	ned by the attending physici	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 9 ☐ Unknown	menths? No		Birth 2 🗀 gnant at time	Fetal death 3	☐ Ectopic pr☐ Other (spe		у				23d. Date of Month	,	/ Year
s, P.O.	signed b		Part II. Other signif		ons contributing to a	/	-	underlying ca	_	ven in Part	I.					ause of death?
of Vital Records,	ate has been si page 2 should b	Completed by										24a. Was	an opsy ormed?	24b. We	re autopsy t	findings available etion of cause of
/ital	is certificate I	To Be (25. Was case referre examiner? 1 Yes 2	ed to medical	Hospital:	Canationt	2 □ ER/Outpatie	ant 3 🗆 DO	Oth	ace of Dea					'Paggifu'	
n of \	After this funeral di		27. Manner of Death	h 5 🗌 Pendi	28a. Date (Mor		28b. Time o	of 280	c. Injury work	y at ?	2	8d. Describe			<i>эреспу)</i>	
The state of the s													or Rural Rou	ite Number,		
Hospir	e Funeral	Medical	(Check 2	Medical I	Physician: To the texaminer: On the banks Nurse Practioner:	sis of examir	nation and/or inve	stigation, in m	y opinio	on, death or	ccurred at 1	the time, date	and plac	ce, and due to	the cause(s	
T of	withir To th comp	2	29b. Signature and			Ver	ND	29c.	icense	82	4			ate signed (#	Month, Day,	
	8		30. Name and Address	ess of person	who completed cau	se of death	(Item 23a) (Type, 0	Print)	T	rive		Glen	Bu	mie,	MO	21061
	Stat Registra		31. Date filed (Mont	h, Day, Year)	32. F	Registrar's S	ignature	,			,					

ORIGINAL

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

10-03344 Dante Ford Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Dante Ford		State - For State	e of Maryland / Depa Cei	artment o <i>rtificate</i> o		na Mentai H		Z U g. No.	0 453
Physicia		Registrar 1. Decedent's Name (First, Middle,La	est)				Date of Death Month		3. Time of Death
Medical Exami	ner	Dante Edward					May 1, 201	0	0051 hrs
		4a. Facility Name (if not institution, give street and number) 6800 block of Baltimore-Annapolis Road			4b. City, Town, o Linthicum	or Location of Death		4c. County of E	del
Funeral Director		220 02 7100	Marks Dave House Min					4 0 7 0 IF	Birthplace (State or or oreign Mauny) Land
any	-	Usual Residence of Decedent 10a. State 10b. County	10c. City,	, Town or Loca	tion				10d. Inside City Limits
	_	Maryland Balti	more Mi	ddle 1	River				1 Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	Directo	10e. Street and Number 2225 Hawthorne	e Road		10f. Zip Code 2122	20	10	g. Citizen of What USA	Country?
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Marrie	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year	lf \		lispanic Origin? (San, Mexican, Puerto		White, e	merican Indian, Black, tc. a.c.k
urs afte tural",	à	3 Widowed 4 Divorce 15. Decedent's Education (Specify	or Dates:	16a. Deceder	nt's Usual Occup	ation (Give kind of	work done	16b. Kind of Busin	ess/Industry
)36 thin 72 hor te. than "na:	Completed by	Elementary/Secondary (0-12) 12th grade	College (1-4 or 5+)		nost of working lif Drive	e. DO NOT use ret		Private	Company
21215-0036 Juld be filed within 77 Mental Hygiene, marked other than c event, the Medical		17. Father's Name (First, Middle, Las Glenn Ford	st)			18.Mother's Name	(First, Middle, M Jones		
212 ould be d Menta s marke	To Be	19a. Informant's Name/Relationship ((Type, Print)	19b. Mailin	g Address (Stre	eet and Number or	Rurat Route Numl	per, City or Town, S	State, Zip Code)
and 2 sho ealth and cen 27 is	-	Glenn Ford/Fat	20h	Place of Disno	cition (Name of c	emeten/	Date	MD 2122 20c. Location - Ci	
Baltimore, MD 21215 permit. Pages I and 2 should be file Department of Health and Mental H Important: If iten 27 is marked of injury or other traumatic event, it		1 Burial 2X Cremation 3 4 Donation 5 Other Specific	Removal from State fy:	crematory or of eenmou	nt Cem	etery ^{5/}	10/10	Baltimo	
Balti permit. Departu Importi injury		21. Signature of Funeral Service Lice	- Harry	5 2	Name and Addres	ss of Facility Ch stersto	atman-E	Jarris E Baltimor	uneral Home e,MD 21215
Physician /Medical		23a. Part I. Enter the disease, or confailure. List only one cause on e	plications that caused the death each line.	n. Do not enter	the mode of dying	g, such as cardiac o	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of						Deatif
	-a	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	of):	-				
	Examiner	cause Enter Underlying Cause	Due to (or as a consequence of	of):					
iO, e be executed ysician and burial - transit	a E	•	d						
O, e be exe ysician burial	ledical	UNPENDED	AMENDED					23d. Date of de	livery
x 6876 h certificate tending phy use as the l	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg	2 F	etal death 3	Ectopic pregna	ancy	Month	Day Year
Box 6876 death certificat the attending ph.	Physician/M	1 Yes 2 No 9 Unknow	4 Pregnant at time of de	eath 5 O	ther (Specify)				
P.O. B ss that the d gned by the	by Ph	Part II. Other significant conditions	contributing to death but not r	esulting in the	underlying cause	given in Part I.		oacco use contribu	te to the cause of death? Probably 4 Unknown
ds, P equires t een sign	eted						24a. Was a	n 24b. We	re autopsy findings available
Recor The law r cate has b	Completed						autops perform 1 ✓ Yes 2	ned? dea	r to completion of cause of th? Yes 2 No
tal Rec cian: The certificate ector, page	Bec	25. Was case referred to medical			26.Plac	ce of Death (Check			
f Vit.	릵	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatien		Other Nursi		Residence 6 🗸	Other: Scene
J O Jing After fune		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) May 1, 2010	0046 hrs		Yes 2 V No	Subject drive	er motorcycle s	struck fixed object
Division Hospital or Attent 24 hours after death Funeral Director:	Certification:	2 Accident Investiga 3 Suicide 6 Could no determin	ot be 28e. Place of Injury - At h			building, etc.			or Rural Route Number, City olis Road, Linthicum, ME
To the Hospita within 24 hours To the Functal completely fille		29a. Certifier 1 Certifying Physi	ician: To the best of my knowled	lge, death occu	rred at the time,	date and place, and	due to the cause	e(s) and manner as	stated.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examin	er: On the basis of examination a and manner stated.	and/or investiga	tion, in my opinio	on, death occurred	at the time, date a	and place, and due	to the cause(s)
	Ž	29b. Signature and title of certifier	1			nse number .M.E.		May 1, 2010	(Month, Day, Year)
	ŀ	30. Name/and address of person who	o completed cause of death (Item	n 23a)					
NV	Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
St Regist	ate rar	31. Date filed (Month, Day Year)	2010 32. Registrar's Signat	ure .	als				
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DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

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DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

320Registrar's Signature

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State Registrar 31. Date filed (Month, Day

DHMH 17 Rev 1/2001

& Pook Rd, Westminster

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 24a per verb., g903 05/10/2010dhb Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5 Yea **Physician** toward 03 2010 0 un /Medical 4b. City, Town, or Location of Death 4c. County of Deat Name (If not institution, give street and number) Examiner Wundel enesis Severna F ark Tune ! everna ark If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept 30, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** ^{Year} 1918 Days Hours 1 M 2 □ F Maryland 91 217-05-8661 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentalle Hygiene. Important: If them 27 is marked other than "natural" or liems 23a or 28a-f show any injury or other traumatic event. The Mardian Experience. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director Pasadena Anne Arundel MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21122 USA 1839 Cremen Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married white 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) US Navy $\tilde{1}^{2}$ electrician 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be Irvin T. Howard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joann Robinson/daughter 365 Quaint Swan Dale Dr; Martinsburg, VA 25404 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Vicensee Ronald S. Wade ²² Name and Address of Facility</sup> Board; 655 W. Baltimore Street Baltimore, Maryland Enter the disease, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Carre (Final disease or condition resulting in death) evebrava rula orlase **Physician** /Medical Due to (or as a consequence of) Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the attending physician and ned for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has bage 2 s autopsy performed? certificate To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA P 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Director: After that in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 ☐ Pending investigation M 1 Tes 2 🗌 No 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier (Pu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

DIANANG

Year)

31. Date filed (Month, Day,

24 Irulan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death In yrs. last birthday)
Yrs. If Under 24 Hrs. If Under 8. Date of Birth Funeral 9. Birthplace (State or Foreign Country) 1 🗆 M 2 🗗 F Months 20nt 28 y, Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygione. Important: If tiern 27 is anawfed other than "natural", or items 23a or 28a-f sho important: If tiern 27 is anawfed other than "natural", or items be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 No 10e. Street and umber 10g. Citizen of What Country? Funeral 21201 vania Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black If Yes, Give Year or Dates. Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done of the control of the control) College (1-4 or 5+) onday (0-12) 64 Be 's Name (First, Midd Aelationship (Type 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place) 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initioted according Examine Due to (or as a consequence of): the burial-tran that initiated events resulting in death) Last ding physician and Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Director: After this certificate 2 **X** No 2 🗌 No Yes 1 Tyes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 은 1 Yes 1 🛱 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending Acciden
Suicide 2 🗆 No Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined within 24 hours a Medical 29a. Certifier 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific STAFF SYLGEOF D69632 address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH DUSOSE J.

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signatura

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2:42 PM Ma 2010 <u>Beulah Jean Hoggard</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospital of Bultimore Baltinone n/a If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) (Month, Day, 1 □ M 2 😾 F Months Min. Director Yrs. 213-36-5798 Virginia Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director MD n/a Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 5214 Kelwav Rd. 21239 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married If Yes, Give Year or Dates. 1 Yes 2 X No Specify: SpecifyBlack 3 ₩ Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Dietician <u>Johns Hopkins Hosp</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Horace Stokes Louise Streat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Ralph Ottoway Stokes (Brother) 1335 Walker Ave. Balto, Md. 21239 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 12,201 1 XBurial 2 Cremation 3 Removal from Sta May 12 n Cem. Crownsville Veteran 4 ☐ Ponation 5 ☐ Other (Specify) Crownsville, Md. grature of Funeral Service Licensee 22. Name and Address of Facility Calvin B. Scruggs Funeral Home 11412 F. Preston St. Balto, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami : Non-st Elevation myocardial infarction that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the buse. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Dav Year 1 ☐ Yes 2 ▼ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hyperlipidemia performed? Yes 2 W No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No 은 1 Yes Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred ■ Natural 5 Pending 1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie cause of death (Item 23a) (Type, Print) son who comple nai 100

State Registrar strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death 3:50 P M Day Month **Physician** 2210 Eichelberger Ivey Jean /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Keswick Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🕅 F 86 Director 579-48-6634 July 3, 1923 Washington D.C. Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 21 No Director MD Baltimore Reisterstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4029 Log Trail Way U.S.A. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: þ Specify: 3 ☐ Widowed 4 🖾 Divorced "natural" White Completed er than "natur the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Professor Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 Is marked traumatic e ٩ Joseph S. Eichelberger Elizabeth Pfeiffer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Department of Health Important: If item 27 any Injury or other to once. Geoffrey Wright Personel Rep 4029 Log Trail Way Reisterstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Ser 5/4/10 Hampstead, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Kisheimer p Erd-Stage Physician Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-fransit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician Physician/Medical the USe IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform certificate 2 No funeral director. 25. Was case referred to medical Be 26. Place Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 V No Certification: To 1 Yes this 27. Manner of Death 28a. Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural (Month, Day Year) 5 Pending investigation 1 Yes 2 No 2 Accident the 1 within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 013657 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 700 W. 40 th STREET, BALTITIONE, MO 21211 MARGREGER, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ANBARA au Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Northwest Hospital Randallstown Baltimore 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD **Funeral** 8. Date of Birth 11-29-1921 1 □ M 2 💢 F Months Days Hours Director 214-12-8973 88 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral hours after death with 940 S. Lakewood Ave., #203 21224 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2XXNo Specify: 3 Widowed 4 X Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Waitress Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary F. Thompson Benjamin Coburn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2914 Jefferson Rd., Spring Grove, PA 17362 Benjamin F. James / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
W. Arundel Crematory 05/08/2010 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility} Rendon-Bailey Funeral Home, PA 2818 E. Baltimore St., Baltimore, MD 21224 21. Signature of Funeral Service M01452 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): ending physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 tending IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 0 in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Year Yes the should be detached ☐ Unknowr 9 Unknow Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate has page 2 autopsy perform Yes 25. Was case referred to medical funeral director, æ 26. Place of Death (Check only one) examiner? Hospital: 1 Tyes Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury hours after death.

neral Director: After the filled in by the funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death Reg. No. 4 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Johnson Larry M. May 6, Year 2010 0900 Medical 4a. Facility Name (if not institution, give street and number)
Holy Cross Hospital **Examiner** 4b. City, Town, or Location of Death Silver Spring Montgomery 5. Social Security Numbe 579–62–3590 . Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 01-24-1947 63 Director virginia Usual Residence of Decedent show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shoi raumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27.5 is marked other than "natural", or items 23a or 28a-f sho any hijury or other traumatic event, the Medical Examiner must be notified at any hijury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Funeral Director 10d. Inside City Limits DC Washington 1 🗆 Yes 2 No 10f. Zip Code 20020 10e. Street and Number 2607 12th Pl. SE 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1964-11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? 1964

1 A Yes 2 No
If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Policeman Dept. Of Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances Morgan ൧ Harrison Johnson Frances 19a. Informant's Name/Relationship (Type, Print)
Barbara Johnson/ Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 113 Rosalynn Ct. Raleigh, NC 27610 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ABurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resurrection Cemetery 5-13-2010 Clinton, MD 21. Sanature of uneral Service Licensee 22. Name and Address of Facili Ronald Taylor II FH 10583 Middleport Ln. White Plains, MD 20695 CON Part 1. Enter the disease, or complications that bused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Metastatic Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Post Obstructive Pneumonia Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year 1 Yes 2 No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Subclavian Thrombus, Coronary Artery Disease Completed 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? Yes 24 No 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🛛 No Other: မ 1 XInpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🕅 Natural (Month, Day, Year) 5 Pending s after death. I Director: Aft work? 2 Accident
3 Suicide Investigation 1 Tes 2 🗌 No completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the To the To the only one) 29c. License number 29d. Date signed (Month, Day, Year) 1/0 D41752 May 6, 2010 man

Registrar

32. Registrar's Signature

1500 Forest Glen Rd. Silver Spring, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bertit Schoellman M.D.

1 0 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Raymond Kitz 06:45 AM 2010 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 07 N/A Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 8. Date of Birth Country)
Mich Months Min (Month, Day, Y Director 385-26-7754 1930 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State Director 10d. Inside City Limits MD GlenArm Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21057 12 Running Fox Road USA 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify: Specify:White 3 ☐ Widowed 4 😾 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working Baltimore Coun_{ty} life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Special Ed. Teacher 12th and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic ew ည Frank Kitz Catherine Dozzi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $107\ W.\ 82nd\ St.\ 1\#A\ New\ York,\ NY\ 10024$ Karen Kitz / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State Dulaney Valley 5/10/10 Cockeysville,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beverly D. Cromart 2700 Edmondson Ave. Balto., MD Cromartie F/S 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ock, or heart failure. List only one cause on each line. Interval Between Onset and Death mediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): 2 wks Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the innerial director, page 2 should be detached for use as the burlar-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cancel 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital: 2 No 1 Yes Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Pendli attre D65718 ,6th,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAL HOSPITAL OF BALTIMORE PENDLI HARITHA MD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 6. 2010 12:15 a^{M} Charlotte Doris Lau Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Lutheran Village Westminster Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🔀 F Months Hours Min. (Month, Day, Year) ec 4, 1919 Maryland Director 215-16-9400 90 Dec Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Medical Framina. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Carrol1 Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 205 St Mark Way 21158 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2X No If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Specify. Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Clerk Giant Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Oscar W. Mechalske Ella McGinnis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Lau Daughter in Law 45 Valleyview Drive Littlestown, PA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery May 10, 2010 | Pikesville, MD 22. Name and Address of Facility 11824 Reisterstown Road Signatur of Funeral Service/Licensee ren enpens ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. erval Between On t an Death Immediate Cause (Final Ph sician/ Due to (or consequence of): disease or condition resulting in death) Medical Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): s been signed by the attending physician and should be detached for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has autopsy performed' 1 Yes 2 No Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Accident Investigation 1 Yes 2 No 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or westigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination 3 Certifying Nurse Practioner: To the best of my within 2 To the f only one 29b. Signature and title of contifier 29c. License number signed (Month, Dav. Year)

State Registrar

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Shoutbens

21157

tet Zell wester Mur

30. Name and address of person who completed cause of ceath (Item 23a) (Type, Print)

32. Registra s Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ April 29, 2010 2340 hrs Medical Examiner David Mitchell, III 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death University Hospital Baltimore N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8, Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Maryland Months Days Min. Hours Director 212-41-8258 16 20,1993 1X M 2 F Dec. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/ABaltimore 1 Yes 2 No Maryland hours after death with the Maryland rector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 826 George Street Ö 21201 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes Black If Yes, Give Year or Dates: 3 Widowed 4 Divorced Yes 2 No specify: Specify: þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 Fornt of Health and Mental Hygiene.

ant; If item 27 is marked other than "r College (1-4 or 5+) 11th grade Student 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Mitchell, Jr. Be Renee Hawkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Renee Mitchell/Mother 826 George Street Baltimore, Maryland 21201 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 5/8/10 4 Donation 5 Other Specify. Greenmount Cemetery Baltim.ore.Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Chatman-Harris Funerl Home MD 21215 Approximate Interval 5240 Reisterstown Rd Baltimore.MD **Physician** 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, List only one cause on each line. Between Onset and /Medical a. Multiple Gunshot Wounds Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical attending physician for use as the burial UNPENDED AMENDED Box 68760, IE FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed Division of Vital Records, 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 No 2 No 1 🗸 Yes Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: this 1 V Yes 2 No After 28a Date of Injury 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Apr 29, 2010 Subject shot 2307 hrs Natural 1 Yes 2 🗸 No Pending the To the Bospital or Atte within 24 hours after dea To the Funeral Director completely filled in by the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 800 West Lexington Street, Baltimore, MD determined (Specify) Local Street Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated g 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 30, 2010 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Melissa Brassell, MD 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Regetrar's Signature State Registrar

DHMH 17 Rev 1/2001

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10016 Month Day Year EVELL 1. 301M 2010 Medical Facility Name (if not institution, give street and number) Examiner 4c. County of Death Hospice Istown Saltimore 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day 01-23 If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F Country) Director Yrs. "natural", or items 23a or 28a-f sho 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits **Funeral Director** Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4130 Mary Avenue 21206 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Yes 2 No If Yes, Give Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Specify: Hlack 3 Nidowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Unit Assistant 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event; the Meones. Elementary/Seconday (0-12) College (1-4 or 5+) Bayview Hospital Be 18. Mother's Name (First, Middle, Maiden Surname, ၉ 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah 4130 Mar Galtimore. Williams Daughter Avenue 20a. Method of Disposition

1 ☐ Burial 2 A Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician ovarian cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ng physician and as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis. Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 - Fetal death Ectopic pregnancy jo in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: ျှ 2 V No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) tent haspile 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Lyapamem.D 00057465 515/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)) 5-235, Balhmore, MD-21209. 2835 5 mith AV. apakse, M.D N.S. Rai 32. Kegistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year MACKLIN 9:27-PM 2010 MA Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMURE HOPKINS BAYVIEW MEDICAL CENTER 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** -4962 1 □ M 2 🔀 F Days Hours Country) Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director undalk 1 ☐ Yes 2 🖼No timore 10e. Street and Numbe 10g. Citizen of What Country? Funeral 21222 usa *lenue* nson Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 2X No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates Decedent's Usual Occupation
 (Give kind of work done during most of working life. O) NOT use retired 15. Decedent's Education (Specify only highest grade completed) Sesonday (0-12) College (1-4 or 5+) 1stodian Be 18. Mother's Name (First, Middle, Maiden Surname) amos ola oung City or Town, State, Zip Code) Dundalk Kobinson Ave. mD 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Donation 5 Dother (Specify) -10 at re of Funeral Service Lie 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death 2 Ph sician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examiner Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Μ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

61

JEN NIFER

31. Date filed (Month, Day, Year)

CHEN

2010

DHMH 17 Rev 7/2009

32. Registrar's Signature

MD 1940 EASTERN WENUE BALTIMORE, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>010</u> Month Physician/ 4:35 Mills Rosie Mae May Ρ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Baltimore 8. Date of Birth (Month, Day, Apr. 19 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2🛣 F Months Davs Hours Min. **Director** 58 214-56-9358 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director MD n/a Baltimore 1 🖵 Yes 2 🗆 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 1173 Kitmore Rd 21239 USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Never Married 2 Married δ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: SpeciBlack 3 Divorced 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. sant: If Item 27 is marked other that ury or other traumatic event, the Nury or other traumatic event the Nury or other event the Nury or o Head Teller Bank_of_America Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Matthew Mills Rosie Hunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trauonce. Ruth Andrews (sister) Leith Walk Baltimore, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Donation 5 🗆 Other (Specify) Maryland Natl.Mem.Pk.May 13, 2010 Laurel, Md. ature of Funeral Service Licensee 22. Name and Address of Facility Calvin B. Scruggs Funeral Home Balto, Md Preston St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): ending physician and use as the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending I completed filled in by the funeral director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a, Was an autopsy performed? Yes 2 prior to completion of cause of death? 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: ျှ 1 🗌 Yes 4 Nursing Home 5 Residence State (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Q

State Registrar park

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death ent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 20109:22 PMMedical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, You Dec 26, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 M M 2 🗆 F Min. Hours Oklahoma Director 70 Ĩ′929 442-28-2638 Usual Residence of Deceden or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2K No MD Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21113 USA 537 Queen Anne Avenue filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 Specify: white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 X Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any Injury or other traumatic event, the N home improvement roofer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gretchen Ruth Monaghan Murriel Merton Nichols 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 537 Queen Anne Avenue; Odenton, Maryland 21113 Verna Bullock/POA 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 X Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Service Licens 22. Name and Address of Facility Ronald Anatomy Board; W. Baltimore Street Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition VHIL Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy☐ Pregnant at time of death 5 ☐ Other (specify)☐ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year cate has been signed by the a page 2 should be detached g 🗌 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 ☐ Probably 4 ☐ Unknown ELLITUS 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate 2 (20No 1 Yes the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 🕱 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending death. 1 🗌 Yes 2 🗀 No М Accident Investigation within 24 hours after death To the Funeral Director: completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature apolitile of certifie 29d. Date signed (Month, Day, Year) address of person who completed cause of death #205

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Amend Item 24a per verb., g903,05/10/2010dhb 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April **Physician** 20[°]10° Рм Enoch Charlie Ndiokho 6:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cottage CLLy

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Sept 3, Prince Georges 4142 Bunker Hill Road; #206 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country UNK **Funeral** 1⊠M 2□ F 1946 579-78-7715 63 Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Extendent must be rediffed at once. 10b County Director 1 Yes 2X No Cottage City MD Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20772 4142 Bunker Hill Road; #206 Funeral 12. Was Decedent Evenin U.S. Armed Forces?UNK 1 ∏Yes 2 ☐ No if Yes, Give Year or Dates: 11. Marital Status unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No à Specify Specify: black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation unic 16b. Kind of Business/Industry unit 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 in and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) unk ŭnk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health ar Corporal Runaldue/police officer 7600 Barlow Road; Landover, Maryland 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages ' 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5♥ Other (Specify) in state Sign rure of Functal Service Lifense Ronald S. W 22. Name and Address of Facility
State Anatomy Board; 655 W. Baltimore Street
Baltimore, Maryland 21201 2222 Part 1 Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part 1 Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cogsequence of) Exami attending physician and for use as the burial-tran Due to (or as a consequence Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an was autopsy performed? has page 2 Oc certificate 0 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □ Other (Specify) ٩ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification: the Hospital or Attending 1 Natural 5 Pending Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Nonth, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

ABIRLH ASAN

ANSAR21 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	tate of Marylan	_	artment of Hea tificate of Dea			ene g. No.2010	4554
	Physicia		1. Decedent's Name (First, Middle, Last) Marion Clyde H	lorace Nib	olett			2. Date of Death April 28		3. Time of Death
`	Medic Examir		4a. Facility Name (if not institution, give street			4b. City, Town, or Loca	ation of Death	ADETT SC	4c. County of Deat	h
	Funeral	634 Senior Way 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date						3. Date of Birth	Wicomi 9. Birt	CO hplace (State or Foreign
	Director		213-42-0408	^{2□} F 67	Yrs.			Month Bay, You	1942 Man	"yland
	/land f show ed at	į	10a. State 10b. County	10c. City	y, Town or Loc	eation				10d. Inside City Limits
	re Mary r 28a-	Director	MD Wicomico 10e. Street and Number		Salisbu	1 ry 10f. Zip Code		Lan		1 🗆 Yes 2 🔀 No
	s 23a c s ust be	Funeral	634 Senior Way			21804		10	g. Citizen of What Co USA	untry?
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fun	11. Marital Status 12. W 1. Never Married 2 Married 1 If	Vas Decedent Ever in U.S rmed Forces? □ Yes 2 ☑ No Yes, Give ear or Dates.	If	Vas Decedent of Hispani Yes, specify Cuban, Me	exican, Puerto Ric	y Yes or No- can, etc.)	14. Race - Amer Black, White Specify: Whi	, etc.
21215-0036	72 hour r "natur edical	nplete	15. Decedent's Education (Specify only highest grade con	on	(Give k	ent's Usual Occupation ind of work done during	most of working	16	6b. Kind of Business I	ndustry unk
212	within giene.		Elementary/Seconday (0-12) Co	ollege (1-4 or 5+)		NOT use retired)				
and	pe filed intal Hy ced oth	To Be	17. Father's Name (First, Middle, Last) Marion William Nibl	lott			Mother's Name (F			-
Maryland	2 should be file th and Mental H ?7 is marked of traumatic ever		19a. Informant's Name/Relationship (Type, Pri		19b. Mailing	g Address (Street and No				Code)
e, G	and 2 s Health em 27 ther tra		Celeste Savage/case		327 Ti	llghman Rd;	Suite 2	00; Sal	isbury, MD	21804
Baltimore,	t. Page 1 rtment of 1 rtant: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 🕏 Other (Specify) 🗓	n state		ition (Name of atory or other place)	Date	e 20	oc. Location - City or	Town, State
Ba	Depar Impo any ir		21. Signation of England rivice Licensee	al	> В.	l'are nd Addeto ff altimore, M	laryland	21201		e Street
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between										
	Physician/ Medical Examiner		disease a condition resulting in death)	Due to (or as a consequ-	ASCUS)				~
		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	ence of):					
	ecuted and -transit	Examiner	cause. Enter Underlying Cause (Disease or initiary that initiated events resulting in death) Last	Due to (or as a conseque	ence of				3	
0	e be exi ysician e burial		d	Duc to (or as a conseque	erice oij.					
98760	ertificate ding physe as the	/Med	IF FEMALE:	use sutes as of						
J. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months?	yes, outcome of pregnan ☐ Live Birth 2☐ Fetal ☐ Pregnant at time of do ☐ Unknown	I death 3	Ectopic pregnancy Other (specify)			23d. Date of deli	very Day Year
JS, P.O.	luires that nn signed I uld be det	by	Part II. Other significant conditions contribut	ing to death but not resu	Ilting in the un	derlying cause given in I	Part I.		co use contribute to t	he cause of death?
Vital Records,	law req has bee e 2 shoi	Completed				24a. Was an autopsy			24b. Were autopsy findings available prior to completion of cause of	
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VITE	hysicia this cert	To Be	examiner? 1 Ves 2 No	1 Inpatient 2 E		Othor		2 /	e 6 Other (Specif	y)
on or	nding Path.: After t	cate:	27. Manner of Death 1 Natural 28. 29. 20. Accident Investigation	a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? M 1 Yes	1	. Describe how i	njury occurred	
DIVISION	al or Atter s after dea I Director d in by the	Certificate:	3 Suicide 6 Could not be	e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stree			Location (Street City or Town, St	t and Number or Rura tate)	l Route Number,
- :	ne Hospite n 24 hours ne Funera	Medical	(Check 2 %) Medical Examiner: On	To the best of my knowle the basis of examination tioner: To the best of my	and/or investig	ation in my oninion deat	th occurred at the	time date and n	laco and due to the co	uco(a) and manner stated
			30. Name and address of person who complete			nt)		3	74110	
	State	e (Chris Swyder Do.	32. Begistrar's Signatu		Salishy	ms 21	w)		
	Registra	~	第 Δ Y ± () ツ() () ()	Nonvera	M M	a Kal				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4555 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 20ÎÖ May Marcia L. Pettit 5:45pm /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 1328 Woodridge Lane **Eldersburg** Carroll 8. Date of Birth (Month, Day Ye NOV 10, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 OV 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year 1942 Days Hours Months Min. 1 □ M 2√□ F 67 Yrs. OK Director 521-60-2341 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Wedical Evancium rougt by multiple of MD Carrol1 1 ☐ Yes 🏌 ☐ No Eldersburg the 10e. Street and Number 10f, Zip Code 10g Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1328 Woodridge Lane 21784 Funeral USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic of Health and Mental Hygid item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gottleib Pflugrath Hulda Krueger ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Rosser J. Pettit (Spouse) 1328 Woodridge Lane, Eldersburg, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation | 5/8/2010 Sykesville, Maryland PO Box 195. Sykesville, MD 21784 21. Signature of Funeral Service Licenses Haio 1400764 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac Immediate Cause (Final **Physician** disease or conditio resulting in death) /Medical Due to (or as a consequence of) Examiner Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transi and Due to (or as a consequence of) Box 68760. physician Physician/Medical as t attending IF FEMALE: nse If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 Month Day Year 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 Other (specify) 0 the þ σ, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use ontribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has tall director, page 2 s 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check on 1 Yes 2 No Hospital: Other: 4 \(\sum \) Nursing Home ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and place and place are the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and place are the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and place are the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and place are the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and place are the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and place are the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place are the basis of examination and occurred at the control of the basis of examination and occurred at the control of the basis of examination and occurred at the control of the basis of examination and occurred at the control occurred at t 29a. Certifier Medical sis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifi 29d. Date s ned (Manth, Day, Year)

State Registrar ame and addr

31. Date filed (Month, Day)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ RICHARDSON OHN Month 5:30 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** or Location of Death SAMARITAN NURSING CTR HIMORE If Under 24 Hrs. 8. Date of Bird **Funeral** 9. Birthplace (State or Foreign Months Director Usual Residence of Decedent ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No 10e. Street and Numbe 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. and Mental Hygiene. is marked other than "natural", or ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h. Kind of Business Industry (Give kind of work done life) DO NOT use retired College (1-4 or 5+) Be Page 1 and 2 should be filed in ment of Health and Mental Hys Father's Name (First, Middle, Last) Jeldon Kichardson Sr Department of Health ar Important: If item 27 is any injury or other trauonce. Battimore Arpnue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner THRIVE Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Month Year 2 🗌 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 1 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Accident Investigation 1 🗌 Yes 2 No Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 10061789

State Registrar 30. Name and address of pers

31. Date filed (Month, Day, Year)

LOPPAINE OFOR -AWVAH, 5430 CAMPBEIL BIND, STE214.BALTIMORE MO21236

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** SMITH BETTY APRIL 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bon Secours Hospital Baltimore 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours 216-48-4212 1 □ M 2 🖵 F 63 Director 28,1946 Maryland Dec. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Baltimore Yes 2□No Mary.land N/A Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21216 2414 Baker Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify. Black Baltimore, Maryland 21215-0036 ò 1 ☐ Yes XXNo 3 ☐ Widowed 4 ☑ Divorced Completed other than "natur 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Mid Town Childrens Elementary/Secondary (0-12) College (1-4or 5+) Child Care Provider Center Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental 7 Is marked traumatic e Laura Seaborn B. Turner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24730 Kimberleigh Rd Baltimore, MD 21212 19a. Informant's Name/Relationship (Type. Print) Health tem 27 I <u>Tina Robinson/Niece</u> permit. Pages 1 and Department of Healt Important: If Item 27 any Injury or other 1 once. 20a. Method of Disposition 20c. Location - City or Town, State Middle River, MD 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, MD 21215 21. Signature of Funeral Service Licensee ewor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final disease or condition resulting in death) SEP 315 **Physician** /Medical Due to (or as a consequence of): Examiner ARTERIOSCLEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine death certificate be executed physician and the burial-transit CEREBRO Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 - Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a I be detached for P.0. 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed HYPERTENTION 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed? 1 Yes 2 No ENCEPHALEPATHY ANOXIC Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 23320 1110. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUDKIR D. PATEL 2000 1300 SECOMP 2000 W131150

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)_

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20h per fh 9903 5-11-10 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Physician/ Day 🧳 Medical **Examiner** give street and number) Town, or Location of Death 4c. County of Death timor If Under 1 Year **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Months Min Director Yrs. permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No more 10f. Zip Code 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. 3 XWidowed 4 ☐ Divorced Slack 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working light QO NOT use retired) nday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, lethod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Ren from State Cedar Hill Cemetery 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No Yes Vital completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Tes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural
2 Accident
3 Suicide
4 Homicide 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 29b. Signature and title of certifie who completed cause of death (Item 23a) (Type, Print) 82 COVANT-BULLIN 3 egistrar's Signat 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6:20 PM^M May 2010 Medical Norma Spence 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 365 Upperlanding Road Security Number 7. Age (In vrs. last birthday) If Under 24 Hrs. **Funeral** If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year 12/7/1924 1 🗆 M 2 🔀 F Months Days Hours Min Country) Maryland **Director** <u>219-16-5926</u> Usual Residence of Decedent or 28a-f show notified at should be filed within 72 hours after death with the Maryland and Mental Hyglene.

Is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 XNo Maryland Baltimore **Essex** 10e. Street and Number 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 365 Upperlanding Road 21221 S. items Α. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. er than "natural", or ite the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married Yes 2 XNo Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Completed 3 X Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 8 Sales Lady Retail traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 t. Page 1 and 2 should be dment of Health and Men rtant: If item 27 Is marke Collins George (unknown) Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr <u>William Spence</u> 365 Upperlanding Road Essex. Maryland 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Lawn Cemetery Signature of Funeral Service Licenses 22. Name and Address of Facility PA Essex, Maryland 21221 51. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. rowin Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) attending physician and resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 2 X No been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? 1 Yes 2 X No After this certificate 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🕅 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury work? in 24 hours are control in Europe. Af Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one

State Registrar d title of certifier

Name and address of person

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who completed cause of death (Item 23a) (Type, Print)

D. Mr. KANA n1D 49

32. Registrar's Signatu

29c. License number

1920 Campbell

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 8, 8:05 P.M May Howard Millard Stierhoff, Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Dove House Westminster 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 8. Date of Birth (Month, Day, 1**XX**M 2 □ F Hours Min Maryland Director 217-26-6919 80Yrs. Aug. 1929 Usual Residence of Decedent shov or 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location Director 1 Tes 2XXNo Maryland Carroll Westminster 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States or than "natural", or items 23a or the Medical Examiner must be Funeral 515 Tremont Drive, 21158 Apt. <u>America</u> filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 2 2 2 2 2 2 2 2 2 3 1 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2XXMarried 3altimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 7th Bricklayer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ other traumatic Oscar Free Stierhoff Mary Emma Eckman 19a. Informant's Name/Relationship (Type, Print) Lyartment of Health an Important: If item 27 is n any injury or other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Y. Darlene Stierhoff (Wife) 515 Tremont Drive, Apt. 1, Westminster, MD 21158 20a Method of Disposition 20b. Place of Disposition (Name of May 10, 20c. Location - City or Town, State 1 Burial 2XXCromation 3 Removal from State Ali Faiths Crematory 4 ☐ Donation 5 ☐ Othe (Specify) Chape 2010 Manchester, Maryland of Fune all 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Road, Owings Mills, MD 21117 Par / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each Interval Between Impediate Cause (Final disease or condition resulting in death) Onset and Death Prysician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any leading to immedicause. Enter Underlying Due to for as a consumence of attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day ģ Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by HOMA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has autopsy performed? Yes 2 🖵 To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes D0145 2 1 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Spe 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred ☐ Natural 5 Pending Investigation 3 Suicide
4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature d title of certifier 29d. Date signed (Month, Day, Year)

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31. Date filed (Month, Day, Year)
MAY 1 0 2010

DHMH 17 Rev 7/2009

Registrar

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32. Registrar's Signature

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Westminster MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ A M Sharon Tune Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore Northwest Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, arch Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 屎 M 2 🗆 F Days Months Hours Min 218-92-3866 Director 44 1956 March MD Usual Residence of Decedent fshow permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore MD 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 832 E. Baltimore Street 21202 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 √ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: SpecifyBlack 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N/A 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cornish William Elaine Tune 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code) 1601 Retreat St. Balto., MD 2121 Cheryl Cornish/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Cr 5/8/10 Woodbine, MD $^{22.\,\mathrm{Name\ and\ Address\ of\ Facility}}$ Beverly D. Cromartie F/S 21. Signature of Funeral Service <u> 2700 Edmondson Ave. Balto., MD 21223</u> 23a. Part 1. Enter the disea c, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. list only one cause on each line. Onset and Death Immediate Cause (Final Physician/ End-Stape AIDS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) signed by the a Id be detached for 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 2 | No 1 Yes Hospital or Attending Physician: **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 4 Nursing Home 5 Residence 6 Pother Specify 2 🖾 No Other: ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) injury 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MSKY MPAMSEM.D 4/28/10 D0057-465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. S. Rajapakse M.D. 2835 Smith Av. S - 203, Baltimore, MD. 21209.

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26. Place of Death (Check only one) 27. Man for of Death 1	. Box 687	ne death certific / the attending ched for use as	ysician/Me	ysician/Mo	ysician/M	nysician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live Birth 2 Fetal of 4 Pregnant at time of de	death 3 Ectopi		У			,
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26. Place of Death (Check only one) 27. Man for of Death 1	ecord	law requi has been ge 2 shoule	mplete	Peripheral Va	scular Dise				auto	psv prior to	completion of cause of			
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W Bind Wagk, M.D. Maryland Greneral Hospital		Hospit 24 hours Funeral leted fill	ledica	(Check 2 Medical Examine)	: On the basis of examination a	and/or investigation,	in my opinio	n, death occurred	at the time, date	and place, and due to the	e cause(s) and manner stated.			
DV Binod Wagle, M.D. To Maryland Greneral Hospital	_	To the within To the comp	2		Tadadier. To the Best of my N				ace, and due to the					
		04		30. Name and address of person who com	pleted cause of death (Item 2	23a) (Type, Print)	and	Gene	RUL:	Gospita	<u></u>			
Registrar MAY 1 (1 2010) A Registrar				31. Date filed (Month, Day, Year)	32. Redistrar's Signatur	re A		2,0,70	7	102/12				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dav Year 2010 <u>Virginia Lee Wilhelm</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Alice Manor Nursing Home Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 1, 1925 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2√2 F Days Hours Min. Yrs Director 218-22-1315 Usual Residence of Decedent or 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho. 10a, State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland N/ABaltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2700 Huntington Ave 21 21 1 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify:White Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Private Industry <u>12th grade</u> Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Virginia Wilhelm ပ Constant E. Wilhelm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Wilhelm/Nephew 518 South Hills Ct Westminster, MD 20901 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Greenmount Cemetery Baltimore, Maryland 22. Name and Address of Facility Chatman-Harris Funeral Home Signature of Funeral Service License town Rd Baltimore, MD 23a. Part 1. Inter the disease, or complications shock, or heart failure. List only one cause ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition a Onset and Death Physician/ MA Medical resulting in death) Examiner Sequentially list conditions Examiner than, leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death ate has been signed by the page 2 should be detached Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate 1 \(\text{Yes} filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 10 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatore and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		-	For State of Maryland / D	Department of F Certificate of D			ene g. No. 2 A A	11.561	
		1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last)				2. Date of Death	6010	3. Time of Death	
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لمسيح			913 Homberg Avenue	Essex	I If I I - do a OA I I was		Baltimore		
	Funeral Director		5. Social Security Number 6. Sex 1 XM 2 F 7. Age (In yrs. last birth	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) 12/14/1	(ear) 9. Birt	hplace (State or Foreign Intry) Insylvania	
			203–24–8579 77 Usual Residence of Decedent			12/14/1	932 FeI	IIISYIVAIIIA	
	land show dat	to	10a. State 10b. County 10c. City, Town	or Location				10d. Inside City Limits	
	Mary 28a-f otifie	Director	Maryland Baltimore Essex					1 🗌 Yes 2 💢 No	
	th the	ョ	10e. Street and Number	10f. Zip Code		10	g. Citizen of What Co	untry?	
	ms 2 musi	Funeral I	913 Homberg Avenue 11 Marital Status 12. Was Decedent Ever in U.S.	21221 13. Was Decedent of Hi	isnanic Origin? (Spe		J. S. A. 14, Race - Amer	doan Indian	
(0	or ite	by Fi	11. Marital Status 1 □ Never Married 2 ☒ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 □ No 1953	If Yes, specify Cuba	in, Mexican, Puerto I	Rican, etc.)	Black, White		
93	rs afte ral", Exar	ed b	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates. 1954	1 Yes 2 X No	Specify:		Specify: Whi	.te	
2-0	2 hou "natu dical	plet	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupa (Give kind of work done of		ng 1	6b. Kind of Business	Industry	
21215-0036	thin 7	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	life. DO NOT use retired)	-		Aero Space	,	
р Б	ed with Hygie other structure.	Be	12 Ma	achinist 	18. Mother's Name			=	
au	be file ental ked c	힏	Fdwin Wolf		Isabelle	, ,	ıknown)		
Maryland	ind Mi s mar umati			. Mailing Address (Street a				Code)	
Σ̈́	d2sl altha 27i ertra		Virginia Wolf (Wife)	913 Homberg	Avenue E	Ssex, Ma	ryland 212	221	
ore	of He		20a. Method of Disposition 20b. Place of	Disposition (Name of ry, crematory or other place			0c. Location - City or	Town, State	
Ĕ	Page ment tant: I		4 Donation 5X Other (Specify Entombrent Holls	y Hill Mem.	Gard. 20	618 M	Middle Rive	er, MD	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Sign Ture of Funeral Service Lieu - 30	22. Name and Address Bruzdzinsk 1407 Old E	ss of Facility Ci Funeral Castern Av	Home PA	sex, Maryl	and 21221	
			23a. Part 1 Enter the disease, or complications that caused the death. Do n shook, or heart failure. List only one cause on each line.					Approximate Interval Between	
	nysician/	6) 3	Immediate Cause (Final disease or condition	NARY A	RTERY	Sid 1	ense.	Onset and Death	
	Medical Examiner		visulting in death) a. Due to (or as a consequence of		/				
	LAMITHE	ř.	Sw. uentially list conditions b.	0					
	sit sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	<i>n</i>):	1				
b.	ecute and I-tran	Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of	of):					
0	icate be executed physician and s the burial-transit	edical	d						
Box 68760	ficate ig phy as the	Med	IF SEMALE.	,					
õ	endin r use	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal death	n 3 🗆 Ectopic pregnanc	су		23d. Date of del		
B 0)	death he att ed for	sici	in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	5 Other (specify)			Month	Day Year	
o.	at the d by t letach		Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause giv	ven in Part I.	23e, Did toba	acco use contribute to	the cause of death?	
ري ص	signe signe	d by	DIABETES			1 ☐ Ye	s 2 🗆 No 3 🗆 P	robably 4 Unknown	
ğ	requi been shoulk	lete	KIDNEY FAIL	WRF.		24a. Was an		topsy findings available	
ecc	e has	Completed	NIDIO / VIII	2011		autopsy perform	prior to death?	completion of cause of	
<u>س</u>	an: Th tificat tor, pa	Be Co	25. Was case referred to medical	26. PI	lace of Death (Check	1 Yes 2	No I Yes	2 🗆 No	
Ζij	ysicia is cer direct	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Ou	stpatient 3 DOA Othe	er: 4 Nursing Ho	me 5 X Resider	nce 6 Other (Spec	ify)	
Division of Vital Records, P.O.	ng Ph ter th neral	ite:		Fime of 28c. Injury		28d. Describe hav	v injury occurred		
ion	tendii leath. tor: Al the fu	ifica	2 Accident Investigation		Yes 2 ☐ No				
Ν	or At after of Direct in by	Certificate:	4 Homicide determined 28e. Place of Injury - At home, fair building, etc. (Specify)	m, street, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,	
Ω	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1X Certifying Physician: To the best of my knowledge, or	death occured at the time	e, date and place, an	d due to the caus	e(s) and manner as sta	ated.	
	n 24 h	Medical	(Check 2 Medical Examiner: On the basis of examination and/o only ong) 8 Certifying Nurse Practioner: To the best of my knowl	r investigation, in my opinio	on, death occurred at	the time, date and	place, and due to the	cause(s) and manner stated.	
	Vithii Vithii Comp	_	29b. Signature and title of certifier	29c. License	e number	29	d. Date signed (Month	n, Day, Year)	
	. \		1 let m		078635	>	05/10/2	2010	
	10x1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	PT- RD.	FORE	HOLIMPA	MD 21052	
	. 0		29b. Signatule and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (In 1990 (251-115		<i>j</i>		,	
	Sta Registra		MATTER ZUTO						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert, Henry, Walton Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Bayview Medical Cente Baltimore Johns Hopkins 6. Sex 8. Date of Birth (Month, Day, Year) Dec 28, 1926 7. Age (*In yr*s. 83 If Under 1 Year | If Under 24 Hrs **Funeral** 225-26-9586 1 X M 2 D F Months Days Hours Min. Director Usual Residence of Decedent show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c, City, Town or Location Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3006 Baybriar Road 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 1945 — Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced Completed 1953 Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) cable installer AT&T Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Ashby Ulmond Jackson Walton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 379 Cedarbrook Drive; Danville, Virginia 24541 Marvin H. Walton/brother 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) State Anatomy Board; 655 W. Baltimore Street Raltimore, Maryland 21201 Signature of Funeral Servi 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. pediate Cause (Final Physician/ Respiratory failure resulting in death) Medical Due to (or as a consequence of) Examiner Aspiration pneumonia Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Exami anding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No jo been signed by the should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 24a. Was an has autopsy
performed?

Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certific completed filled in by the funeral director, of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Yes 2 🗹 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending Division 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Year Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29c. License number 29d. Date signed (Month, Day, Year) May 4, 2010 Res- 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue Battimore 21224

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

days

days

1X Yes 2 ☐ No

Virginia

white

1900 PM

2010

Registrar

29b. Signature and title of certifier

SUSAMNA

Susama MNo

M NAZARIAN

MD PhD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 06^{ay} MAY FREDERICK WEINSTEIN 2ິທີໃດ 7:10 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1/22/1922 216-12-3097 88 Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 🕅 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 6 HARROW COURT 21208 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE If Yes, Give Year or Dates 3 X Widowed 4 Divorced Specify. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DENTIST DENTISTRY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ WEINSTEIN BENJAMIN GERTRUDE SHAPIRO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALLAN WEINSTEIN/SON 6936 COPPERBEND LANE, BALTIMORE, MD 21209 injury or other 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State BETH EL MEMORIAL PK 5/7/2010 RANDALLSTOWN, MD Depation 5 Other (Specify) f Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) as a consequence of Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 2 🗌 No been signed by the should be detached 9 Unknown Unknown t II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signated by page 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown dist 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an perform certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to me examiner? 26. Place of Death (Check only one) 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of De th 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 1 Natural (Month, Day, Year) injury 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined building, etc. (Specify) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year

(M NOCHO)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 37 ANDERSON LUCILLE Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. (In yrs. **79** Date of Birth (Month, Day, Ye 9. Birthplace (State or Foreign **Funeral** 1 M 2 K **Director** 248-38-5903 SC 8/21/1930 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director MD 1 X Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 727 DRUID PARK LAKE DRIVE 21217 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 1 Never Married 2 Married 1 Yes 2 XNo If Yes, Give BLACK 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOUSEWIFE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) THOMAS ANDERSON PEARL OWENS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS ANDERSON/SON 3006 BRENDAN AVE., BALTIMORE, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ON-SITE-CREMATION 5/11/10 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JAMES 21. Signature of Funeral Service Licensee A-MORTON LSONS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Card ovar cular osclero to disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; 1 Yes 2 No After this certifica funeral director, p Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **Z** No 1 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funera 1 Natural (Month, Day, Year) work? 5 Pending 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MARY 2. DBULLOTA PGY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Re ate filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 4th Year Month Physician PEARL ANDREWS 8:00 PM EMILY MAY 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE GENESIS PERRING PARKWAY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign 8. Date of Birth Month, Day, 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 F O Director 10a. State 10b. County 10c. City, Town or Location od. Inside City Limits show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinant must be modified at 1 Des 2 □ No Director timone 10g. Citizen of What Country? and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Was Decedent Ever in U.S Armed Forces? 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 No Specify: à 3 Vidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
ite. DO NOT use retiged) 16h Kind of Business/Industr College (1-4or 5+) Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnar, Be should be ပ 19b. Mailing Address (Street and Number or Rural Route Number, r Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra 3altimore, 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Nation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral e vice Licensee CLA Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Demen Physician Advanced years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 Other (specify) P.0. s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ decerbi 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐ No Anemia 24a Was an certificate has autopsy page 2 tion due to dementia Malnutri 1 ☐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 🔀 No 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🗷 Natural 1 ☐ Yes 2 ☐ No within 24 hours atter death.

To the Funeral Director: A completely filled in by the fu r death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 96 D0058 6 1801 Wentworth Koad 30. Name and address of person who completed cause of death (Herry 23a) (Type, Print) KHAWAJA M.D

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

MAY 11

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month **Physician** 2010 Winona E. Anderson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. N/A 2 Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Min. Days Hours 1 □ M 2 □ F Director 217-22-4276 Nov.11, 1925 Maryland. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important; If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eva; the rout to rediffed and once. Director 1 TYes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 301 McMechen Street 21217 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2□No Baltimore, Maryland 21215-0036 1 □ Yes 2 □ No Specify Specify: ò 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Security Admin. **Employee** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leewood Macer Ruth Macer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tonia Pittman 7404 Ripple Court Windsor Mill, Maryland 21244 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 04/30/10 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, Maryland Metro Crematory Inc. 21. Signature deral Service Lic 22. Name and Address of Facility Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md 21217 ode of dying, such as cardiac or respiratory arrest, 23a. Patt 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death leath. Do not enter the mode Immediate Cause (Final **Physician** day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner vere DSei Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons guence of) Examine sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 ☐ No Month Dav Vear 5 ☐ Other (specify) signed by the a t be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 4 Unknown cate has been si page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate 2 No Yes 2 No Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **N**o 2 ER/Outpatient 3 DOA Certification: To Inpatient this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural
2 Accident 5 Pending injury death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner to shall be dead of the cause(s) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) manner stated.

State Registrar

DHMH 17 Rev 1/2001

ANN REE 31. Date filed (Month, Day, Y

29b. Signature and title of certifier

30. Name and address of person who complet ause of death (Item 23a) (Type, Print)

Year)

900CATONAVE
32. Registrar's Signature

29c. License number

BALTIMORE MOZ

29d. Date signed (Month, Day, Year)

2010

Examiner Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran

Physician

/Medical

Examiner

10a. State

Funeral

Director

"natural", or items 23a or 28a-f shov ofical Examiner must be notified at

= 5 permit. Page Department of Important: If any Injury or once.

Physician

/Medical

Directo

Funeral

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Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

resulting in death)	Due W (or as a consequence of):			
Sequentially list conditions, any loading to important cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Du to (or as a consequence of): c	ancer		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		pic pregnancy er (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions of	contributing to death but not resulting in the underly	ing cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
-			24a. Was an autopsy performed?	
25. Was case referred to medical examiner?		26. Place of Dea	th (Check only one)	
1 Yes	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 [□ DOA Other: 4 □ Nursing H	ome 5 Residence	6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1	28c. Injury at Work?	28d. Describe how inj	
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	ctory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)
	nysician: To the best of my knowledge, death occu niner: On the basis of examination and/or investig and manner stated.			
29b. Signature and title of certifier	PND Attending Physician	29c. License number D 5 /8 5		Date signed (Month, Day, Year)
30. Name and address of person who	completed cause of death (Item 23a) (Type, Print)	In Handver	Street	Boltmare 21225

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Nellie C. Brandon 11:15 P^M 4 28 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frankford N/H Balto na If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Months Hours 1 □ M 2√2 F 99 215-30-0838 Director 12-1-1910 N.C Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It a Medical Exp. timer must be a difficult and once. 1 √Yes 2 No Director MD na Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5009 Frankford 21206 Avenue U S Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Black 2 Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <u>llth grade</u> <u> Housewife</u> <u>Home</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Weldon Richardson Ada Hawley 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antoine Tull-Grandson Rush Vine Ct Owings Mills, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) KIng Memorial Pk 5-4-2010 Randallstown, MD March East F/H 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 1101 E. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, many, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as the IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) ☐Yes 2☐No 9 Unknown signed by t the detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed this certificate 2 No 1 □ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Man of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident **Director:** 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Momicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

Records, Division of Vital within 24 hours a

> State Registrar

29b. Signature

and title of certifier

strar's Signature

and manner stated.

8

pleted cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

19m Woods Road MI) 21234

10-03255 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. J Henry Banz, Jr. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ J. Henry Banz, Jr. **Medical Examiner** April 27, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1905 Stockton Road Joppa Harford 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Hours Min. Director 01 - 27 - 1948218-58-2605 1 XM 2 F 62 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show MD Harford tem 27 is marked other than "natural", or items 23a or 28a-fsho traumatic event, th<u>e Medical Examiner must be notified at once.</u> Joppa Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 1905 Stockton Rd 21085 USA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 No specify: Specify: ğ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 2 Mail Clerk 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) J. Henry Banz, Sr. Marguerite L. Peters 19a. Informant's Name/Relationship (Type, Print) Margie R. Killian (Sister) Joppa, MD 21085 1905 Stockton Rd If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Parkwood Cemetery 05-01-2010 4 Donation 5 Other Specify. 21 Signature of Funeral Service License Physician failure. List only one cause on each line /Medical a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transit Physician/Medical UNPENDED AMENDED IF FEMALE: 23c, if yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth 2 Fetal death Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed ificate has been si r, page 2 should b 24a, Was an performed? Yes 2 ✔ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 this ER/Outpatient 3 DOA 1 V Yes 27. Manner of Death 28b. Time of Injury 28c. Injury at Work?

8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Country) MD 10d. Inside City Limits 1 Yes 2 X No 10g. Citizen of What Country? 14. Race - American Indian, Black, White, etc. White 16b. Kind of Business/Industry Post Office 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State Parkville, MD 22 Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd BelAir, MD 21014 Part I. Later the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death Division of Vital Records, P.O. Box 68760, 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No Other Nursing Home 5 Residence 6 🗹 Other Scene After 28a Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 V Natural 1 Yes 2 No 5 Pending in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 28, 2010 30 Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Span, Registrar's Signature State all

1906 hrs

Registrar DHMH 17 Rev 1/2001

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Standard	Physicia	n	State Registrar 1. Decedent's Name (First, Middle, Last) I did T. Decedent's to the first			Cer	шсате	of Dear		2. Date of Death	Day	Year	3. Time of Dea
213-26-7049 10 Mode			4a. Facility Name (If not institution, give s	treet and number)			-			may 3,	4c. Count	-	
Charles A. Johnson 19a. Informats Nama-Relationship (Type Print) 19b. Mailing Address (Street and Number or Rusual Route Number. City or Town. State. Zip Code) 1719 Maiden Choice Lane BR224; Catonsville, MD 2122 20a. Method of Disposition 1 (Datum 2 Coremation 3 Removal from State Double	irector		213-26-7049	M 257 F		**			rs Min.	8. Date of Birth (Month, Day, Sept. 24	Year) ,1929	9. Birth Cou New	place (State or Fo ntry) Jersey
Charles A. Johnson 19a. Informatis Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rusual Route Number of Type Type Type Type Type Type Type Type	28a-f show	.	MD Baltimore				ille	ode		10	og. Citizen of		1 □ Yes 218
Charles A. Johnson 19a. Informatis Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Runnin Foulton Number. City or Town, State. Zip Code) 19a. Informatis Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Runnin Foulton Number. City or Town, State. Zip Code) 17a. Mailing Address (Street and Number or Runnin Foulton Number. City or Town, State. Zip Code) 17a. Mailing Address (Street and Number or Runnin Foulton Number. City or Town, State. Zip Code) 17a. Mailing Address (Street and Number or Runnin Foulton Number. City or Town, State. Zip Code) 17a. Mailing Address (Street and Number or Runnin Foulton Number. City or Town, State. Zip Code) 17a. Mailing Address (Street and Number or Runnin Foulton Number. City or Town, State. Zip Code) 17a. Mailing Address (Street and Number or Runnin Foulton Number. City or Town, State. Zip Code) 17a. Mailing Address (Street and Number or Runnin Foulton Number. City or Town, State. Zip Code) 17a. Mailing Address (Street and Number or Runnin Foulton Number. City or Town, State. Zip Code) 17b. Mailing Address (Street and Number or Runnin Foulton Number. City or Town, State. Zip Code) 17b. Mailing Address (Street and Number or Runnin Foulton Number. City or Town, State. Zip Code) 17b. Mailing Address (Street and Number or Runnin Foulton Number. City or Town, State. Zip Code) 17b. Mailing Address (Street and Number or Runnin Foulton Number. City or Town, State. Zip Code) 17b. Mailing Address (Street and Number or Runnin Foulton Number. City or Town, State. Zip Code) 17b. Mailing Address (Street and Number or Runnin Foulton Number. City or Town, State. Zip Code) 17b. Mailing Address (Street and Number or Runnin Foulton Number. City or Town, State. Zip Code) 17b. Mailing Address (Street and Number or Runnin Foulton Number. City or Town, State. Zip Code) 17b. Mailing Address (Street and Number or Runnin Foulton Number. City or Town, State. Zip Code) 17b. Mailing Address (Street and Number or Runnin Foulton Number. Ci	iral", or items 23a or	by Funeral	11. Marital Status 1 1 ☐ Never Married 2 ☑ Married	2. Was Decedent E Armed Forces? 1 ∐Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ver in U.S			nt of Hispanic Cuban, Mex			14. Ra Bla	ack, White, נגד	etc.
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Harry Buchheister Husband 719 Maiden Choice Lane BR224; Catonsville, MD 2122 20a. Method of Disposition 125unia 2 cremation 3 Removal from State 20c. Disposition 125unia 2 cremation 3 Removal from State 20c. Disposition 125unia 2 cremation 3 Removal from State 20c. Disposition 125unia 2 cremation 5 Genetic (Specify) 5 / 11 / 2010 Baltimore, MD 21. Signature of Invariant Service Licenses (Jacob Park Cemetery) 5 / 11 / 2010 Baltimore, MD 21. Signature of Invariant Service Licenses (Jacob Park Cemetery) 5 / 11 / 2010 Baltimore, MD 21. Signature of Invariant Service Licenses (Jacob Park Cemetery) 5 / 11 / 2010 Baltimore, MD 21. Signature of Invariant Service Licenses (Jacob Park Cemetery) 5 / 11 / 2010 Baltimore, MD 21. Signature of Invariant Service Licenses (Jacob Park Cemetery) 5 / 11 / 2010 Baltimore, MD 21. Service Invariant Service Licenses (Jacob Park Cemetery) 5 / 11 / 2010 Baltimore, MD 21. Service Invariant Service Licenses (Jacob Park Cemetery) 5 / 11 / 2010 Baltimore, MD 21. Service Invariant Service Licenses (Jacob Park Cemetery) 5 / 11 / 2010 Baltimore, MD 21. Service Invariant Service Licenses (Jacob Park Cemetery) 5 / 11 / 2010 Baltimore, MD 21. Service Invariant Service Licenses (Jacob Park Cemetery) 5 / 11 / 2010 Baltimore, MD 21. Service Invariant Service Licenses (Jacob Park Cemetery) 5 / 11 / 2010 Baltimore, MD 21. Service Invariant Service Licenses (Jacob Park Cemetery) 5 / 11 / 2010 Baltimore, MD 21. Service Invariant Service Licenses (Jacob Park Cemetery) 5 / 11 / 2010 Baltimore, MD 21. Service Invariant Service Licenses (Jacob Park Cemetery) 5 / 11 / 2010 Baltimore, MD 21. Service Invariant Service Licenses (Jacob Park Cemetery) 5 / 11 / 2010 Baltimore, MD 21. Service Invariant Service Licenses (Jacob Park Cemetery) 5 / 11 / 2010 Baltimore, MD 21. Service Invariant Service Licenses (Jacob Park Cemetery) 5 / 11 / 2010 Baltimore, MD 21. S	ا هوا	Be	Charles A. Johnson			401 14 11	a Adding 1	Kat	hryn 1	E. Johns	on		Code
23a. Part Kiner the disease, of oringinications that cause's the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mendate Cause (Final Immediate Cause (F =	-	Harry Buchheister 20a. Method of Disposition	Husband	20b. Pl	719 Ma	aiden	Choice	Lane	BR224;C	atonsv	ille,	MD 2122 own, State
23a. Part Line the disease, of omiplications that cause's he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mendate Cause (Final International Cause (mportant: I any Injury o once.		4 ☐ Donation 5 ☐ Other (Specify)		Lou	don Par	rk Cem Name and . Funera	Address of Fa	of C	erling A atonsvil	shton le, In	Schwa	b Witzke
Part II. Other significant conditions constituting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 1	edical miner		shock, or heart failure. Lift only on immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, is a in a lift of the cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequ	Do not ente	r the mode	of dying, such	as cardiac	or respiratory arre			Approximate Interval Between
Total Significant Control State of Death (Check only one) 24a. Was an autopsy performed? 1 Yes 2 No No Year) 1 Yes 2 No No Year) 1 Yes 2 No Year Year Yes 2 No No Year Yes 2 No Y	by the attending physitached for use as the	hysician/Medi	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 ☐ Live birth : 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal time of de	death 3 ☐ eath 5 ☐	Other (spec	eify)			N	lonth	Day Year
Company Comp	been signed should be de	ò	Part II. Other significant conditions con	ributing to death bu	l Lit	ting in the un	derlying cau	se given in Pa	urt I.	1 □ Ye	s 2010	3☐ Pro	bably 4 ☐ Unkr
The state of the specified of the state of t	ertificate has	0	examiner?					26. PI	ace of Deat	autops perforn 1 □ Yes 2	y ned? : □ No	prior to co death?	impletion of cause
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and daddress of person who completed cause of death (Item 23a) (Type, Print)	Director: After this of in by the funeral director	္ ၂	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of injur (Month, Day)	y Year) ry - At hor	28b. Time of Injury	280 M	High High High High High High High High	□No	28d. Describe ho	w injury occu	rred	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	To the Funeral	edical	(Check only 2 Medical Examinone)	er: On the basis of	examinat ted.	ion and/or inv	estigation, in	n my opinion,	death occur	red at the time, da	ate and place	, and due t	to the cause(s)
	- 3		30. Name and address of person who cor	npleted cause of de	ath (Item	23a) (Type, F	Print)	00	200	475	516	110	- (6

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

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32. Registar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death nt's Name (First Physician/ 2010 MAY Medical own, or Location of Death **d** Death 4b. City 4c. County Examiner 8. Date of Birth **Funeral** Months Director "natural", or items 23a or 28a-f shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho array hijury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 - Yes 2 440 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White 1 Never Married 2 Married 1 ☐ Yes 2 I If Yes, Give Year or Dates Completed by 2 Maryland 21215-0036 2 1 No Specify: 3 Widowed 4 Vorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Be Baltimore, 5 Other (Specify) 21225 23a. Part 1. Enter the disease, or comp ations that caused the death. Do not enter the mode of d Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Physician/ MYDEE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed rate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a cons Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Fctonic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s perform 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: Certificate: To 1 Tyes 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and file of co 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 201 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

10-03532 Bryan J. Braun

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2010 14576

		1- For State Registrar				Certif	ficate of	Death				Reg. No.			
Physicia		1. Decedent's Name (I	First, Middl	e,Last)							2. Date of Do Month		Year		3. Time of Death
Medical Exami	ner	Brya	n	J		Braun					May 7, 2		Tear		0907 hrs
		4a. Facility Name (if no University Hos		n, give street and no	umber)		41	o. City, Town, o Baltimore		of Death		4c.	County of	Death	
Funeral		5. Social Security Num	nber	6. Sex	7. Age (I	In yrs. last	birthday)	If Under 1 Ye	ar If Und	der 24Hrs.	8. Date of	Birth(MM/I	D/YYYY)	9. Birt	hplace (State or
Director		212-27-5349	ı	1X M 2 F		25	Yrs.	Months Da	ys Hour	rs Min.	Februa	rv 18	1985	Foreig Co	n ^{untry)} Maryland
		Usual Residence of De	ecedent		-						- ODI GE	19 10,	1,00		TELL Y ICHEL
' any		10a. State 10	b. County		10	c. City, To	wn or Locatio	n							10d. Inside City Limits
laryland 8a-f show at once.	5	Maryland	Anne A	Arundel	F	Pasader	na								1 Yes 2 No
Maryl 4 28 2-1 d at 9	Director	10e. Street and Number	-					10f. Zip Code				10g. Citiz	en of Wha	t Cour	ntry?
th the Maryland 23a or 28a-f sho notified at once.		7890 Mansion	House	Crossing				21122					U.S.	Α.	
h with	Funeral	11. Marital Status 1 Never Married	. D.	12. Was Dec	cedent Ev	er in U.S.		Decedent of H				No-	14. Race - White,		can Indian, Black,
r deat or its	ᆵ			1 Yes	2 A	No	-	-			110011, 010.7		viinto,		
s afte	þ	3 Widowed		or Dates:				res 2 X N					Specify:		ite
hour natu	ted	15. Decedent's Educ Elementary/Second			de comple 1-4 or 5+)			s Usual Occupa st of working lif				16b, Ki	nd of Busi	iness/Ir	ndustry
)36 thin 72 hours a ne. than "natura edical Examin	Completed	12	ary (0-12)	N/A	1-4 0(5+)		Longsh	oreman				J π	A Loca	a1 0	53
5-00 led with Hygiene other the Me	ĕ	17. Father's Name (Fir	st, Middle,					OT CILLII	18.Mothe	r's Name (First, Middle			JL 7.	
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Gary	s.	Brau	ın				Sheil:		, , , , , ,	,	Hari	ris	
2121 hould be find Mental is marked tric event,	2	19a. Informant's Name	/Relationsh	nip (Type, Print)			19b. Mailing	Address (Stre			ıral Route Ni	umber, Cit			Zip Code)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. I ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once		Gary S. Braun		ner)			7890 Mai	nsion Hou	ıse Cr	ossing	Pasade	na, Ma	ryland	1 21	122
	1	20a, Method of Dispos 1 X Burial 2		2 Pomoval fr	am Stata		e of Dispositi	on (Name of ce r place)	emetery,		Date	20c. L	ocation - C	City or	Fown, State
Page onto	Ш	4 Donation 5	_		om otate	Cedar	Hill C	emetery		05/12	/10	Bro	oklyn	Parl	k, Maryland
Baltimore, permit. Pages I at Department of Her Important: If ite injury or other tr			21. Signature of Funeral Service Licensee 22. Name and Address of Facility MCUILLy—Polymiak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland												
		Som	=7	Allin			320	Mounta	in Road	d Pasa	dena, M	arylan	d 2112	22	
Physician /Medical		23a. Part I Enter the d			aused the	death. Do	not enter the	mode of dying	, such as	cardiac or	respiratory a	rrest, shoo	k, or hear	t	Approximate Interval Between Onset and
Examiner		Immediate Cause (Finance condition resulting in		a. Cardi			hmia								Death
1				Due to (or as a			Inter	etitia	1 Fib	rocio					
	힏	Sequentially list condit if any, leading to imme	diate	Due to (or as a			. Inter	BCTC1a.	1 110	TOSI	,				
	Examiner	cause. Enter Underlyi (Disease or injury that	initiated	c. Due to (or as a		ones of									
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e exection a rial - 1	edical	XUNPENDED		AMENDED AMENDED	23a,	line l	perM	E,G905, /1/10	7/26/ TT	/2010	,WS				
3760, ficate be g physici s the buri	⋝ I	IF FEMALE: 23b. Was decedent pre	annet in the	23c. If yes,	outcome o	of pregnant	су					23d.	Date of de	elivery	
	ia	past 12 months?	griant in the	Linep		e of death		death 3	Ectopi	c pregnan	СУ	N	onth	Da	ay Year
Box 68760 he death certificate b the attending physi	Physicia	1 Yes 2 No 9	9 Unkr			o or acair	5 Othe	r (Specify)		,					
D. E. It the a sched		Part II. Other significa	ınt conditio	ons contributing to	death bu	t not result	ting in the und	derlying cause	given in Pa	art I.	23e. Did	tobacco us	se contribu	ute to th	ne cause of death?
ires that the signed by I be detach	a p										1 🗌 Ye	es 2 🗸	No 3	Proba	ably 4 Unknown
rds requir	ete						= -				24a. Was				opsy findings available
e law e has	Completed											ormed?	dea	th?	mpletion of cause of
Reference True True True True True True True Tru		25. Was case referred	to medical					26 Place	e of Death	(Check or		2 No	1	/ Yes	2 No
Vital Records, ysician: The law required in secutificate has been a director, page 2 should	B B	examiner?	No	Hospital: 1	npatient	2 FR	/Outpatient		Other ₄		Home 5	Residen	e 6	Other:	
n of Viding Physic	H	27. Manner of Death	1140	28a. Date	·		b. Time of Inju		ry at Work		8d. Describe				
Sion of Vital Records, P.O. Box 68 Attending Physician: The law requires that the death certificate. Teach. extern: After this certificate has been signed by the artendin by the funeral director, page 2 should be detached for use a	흸	1 X Natural 5		ng `	, Day, rear)			1	Yes 2	No					
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been sited in by the funeral director, page 2 should the sine by the funeral director, page 2 should the sine by the funeral director.		2 Accident 3 Suicide 6		not be 28e. Place	e of Injury	- At home,	, farm, street,	factory, office	building, et	tc. 2			Number	or Rura	al Route Number, City
Dipital of purs at ceral D	Certification:	4 Homicide	deterr								or Town,	State)			
Divis To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	_	(circuit circy		ysician: To the bes	-										
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	~ 💌		niner: On the basis of and manner s		auon and/o	investigation			curred at t	ne ume, date		_		
	2	29b. Signature and title	or certifier	18				29c. Licens				1			th, Day, Year)
		Morgani	eVh	e Strile				O.C.	IVI.⊏.			Iway	3, 2010 		
ϕ		30. Name and ad ress Margarita Kore		who completed caus Assistant Med				n Street, B	altimore	e, MD 21	1201				
	ate	31. Date filed (Month, D	Day Year)	32. Re	gistrar's	gnature	ake								
Regist	GI.	1771	7010	1	1	1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 8 Physician/ Henry Bush 19:30 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9015 Swan Avenue Edgemere Baltimore Social Security Number If Under 1 Year If Under Funeral Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 🗆 F Months Days Hours February 26, 1941 Country)
Maryland 217-40-9814 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Edgemere 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 9015 Swan Avenue 21219 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian Armed Force , or Black, White, etc. 1 Never Married 2 X Married Completed by Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give White "natural", 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 years vears Commerical Crabber Waterman other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry D. Bush Ella M. Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9015 Swan Avenue, Edgemere, Maryland Jane Bush wi fe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 14. Page 1 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or Bayview Crematory Baltimore, Maryland 2010 Signature of Funeral Service Licen e 22. Name and Address of Facility

Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death and Death Physician/ disease or condition resulting in death) Medical ue to fir as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Day Month Pregnant at time of death 5 Other (specify) Year 2 No ed by the a detached t g Unknown g Unknown signed to Part, II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown ns certificate has been si director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Yes 25. Was case referred to edical Be 26. Place of Death (Check only one) examiner? Hospital: 2 1 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 5 ☐ Residence 6 ☐ Other (Specify) this 4 Nursing Home 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural iniurv work? 1 ☐ Yes 2 ☐ No Investigation
6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) e and title of certifier 29d. Date signed (Month, Day, Year,

State Registrar

10-03483	
David Beers	

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avid Beers		State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2010 14578											
Physici	an/	Registrar 1. Decedent's Name (First, Middle,I	Last)			Dealit		- T2	. Date of D).	Т	3. Time of Death
edical Exam				rs					Month May 5, 2	Day 2010	Year		1245 hrs
		4a. Facility Name (if not institution,	give street and nun	nber)	4	b. City, Town, or	Location of D				c. County of	Death	
		University of Maryland N	Medical Center			Baltimore							
Funeral		· · · · · · · · · · · · · · · · · · ·	. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year			8. Date of	Birth (MN	(/DD/YYYY)		nplace (State or Foreign ntry)
Director		213.88.4155	M 2 F	49	Yrs.	Months Days	Hours	Min.	01.	04.	1961	MI	• •
,		Usual Residence of Decedent		Lie de								1,11	
ow any		10a. State 10b. County			r, Town or Locatio	on							10d. Inside City Limits 1 Yes 2 No
yland f sho	tor	unk unk		un	K	405 71: 0 - 1:				10 0			Unk
ne Maryland or 28a-f show fied at once.	Director					10f. Zip Code					tizen of Wha	it Count	ry?
r death with the Maryland or items 23a or 28a-f sho must be notified at once.	al D	unk 11. Marital Status	I 10 Wee Deep	dest Francis II	10 142 144-	unk		1.0.	-:f . V		S.A.	A	Dist.
eath with the items 23a	Funeral	1 Never Married 2 Marri	12. Was Dece	rces?		Decedent of His s, specify Cuban				NO-	White,		an Indian, Black,
her de	/ Fu	3 Widowed 4 Divorce	1 Yes ced If Yes, Give Year	2 No	1	Yes 2 No	specify:				Specify:	whi	te
urs af itural	d by	15. Decedent's Education (Specify	or Dates:		16a. Decedent	s Usual Occupati	ion (Give kind			16b.	Kind of Bus		
72 ho n "na	Completed	Elementary/Secondary (0-12)	College (1-	4 or 5+)		st of working life.	DO NOT use	eretire	d)	1.	. 1.		
036 Arthin r tha	d d	8			unk					ur	ıĸ		
15-0 illed v Hygi d oth	ပိ	17. Father's Name (First, Middle, La	ast)				18.Mother's N	lame (F	irst, Middle	e, Maider	Surname)		
d be f fental farke event	o Be	Norman Beer 19a. Informant's Name/Relationship	s, Sr.		Lane Marillan	Address (0)	Patri	<u>lci</u>	a El	izak	<u>beth</u>	Н	all
s, MD 21215-0036 and 2 should effice within 72 hours after death with the Maryland feath and Montal Hygie within 72 hours after death with the Maryland term 21 is marked other than "natural?, or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	ř				602E	Fairde	tand Number	rorku	ral Route N	umber, C	ity or Town	, State,	21234
and 2 and 2 fealth tem 2 traur		Eric Beers/Br 20a. Method of Disposition	other	20b.	Place of Disposit				Date	20c.	Location - 0	City or T	own, State
DOF 10 of 1 11 of 1 11 of 1		1 Burial 2 Cremation		III Olate	crematory or other			\ E	11 1				
Baltimore, MD 21215-0036 pemit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		4 Donation 5 Other Spec 21. Signature of Funeral Service Lice			hesape		4 - 77					-	e, MD
E Per De li	W 2	La de Sue R	H	10144	S 87	17 Gree	n Pas	CAF	A/St res	ephe Dr.	Balt	o,n	hrmann, P MD 2128
Physician		23a. Part. Enter the disease, or co failure. List only one cause on	mplications that car	used the death									Approximate Interval Between Onset and
Examiner			a. Blunt Force	Injuries									Death
		or condition resulting in death)	Due to (or as a d	consequence o	of):								
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a c	consequence o	of):								
	E cause. Enter Underlying Cause C Consease or injury man initiated									153			
ted Insit	Examiner	events resulting in death) Last	Due to (or as a d	consequence o	of):								
be executed isician and urial - transit	dical	UNPENDED	AMENDED										
60, ate be thysici	Med	IF FEMALE:	23c. If yes, ou	utcome of preg	nancy					23	d. Date of d	elivery	
687 ertific ding p	an/	23b. Was decedent pregnant in the past 12 months?	1 Live bir			I death 3	Ectopic pre	egnanc	у		Month	Da	y Year
Box 68760, e death certificate but the attending physic ed for use as the but	Physician/Me	1 Yes 2 No 9 Unkno		nt at time of de	5 Othe	er (Specify)				- 1			
O. E	P.	Part II. Other significant condition			esulting in the un	derlying cause gi	ven in Part I.		23e. Did	tobacco	use contrib	ute to th	e cause of death?
P.O. es that the igned by be detached	J b								1 🗌 Y	es 2	No 3	Proba	bly 4 Unknown
rds, requir	Completed								24a. Wa				psy findings available
e law e has ge 2 sl	ם		#1 # #					-	per	opsy formed?	de	ath?	mpletion of cause of
I. The		25. Was case referred to medical	1			26 Place	of Death (Ch	eck onl		2N	1	✓ Yes	2 No
/ita /sicia nis cer direct	o Be	examiner?	Hospital: 1 🗸 Inj	patient 2	ER/Outpatient		Othor:		lome 5	Reside	ence 6	Other:	
of \officers	-	27. Manner of Death	28a. Date of	f Injury	28b. Time of Inj	ury 28c. Injury	y at Work?			e how inj	ury occurred	i	
Division of Vital Records, ral or attending Physician: The law requirers after death. To after death. To Director: After this certificate has been sited in by the funeral director, page 2 should be	ţį	1 Natural 5 Pending 2 Accident Investig		010'	1524 hrs	1 Y	es 2 🗸 No	St	ubject wa	as assa	aulted		
ViSi or At frer d Direct in by	iţi	3 Suicide 6 Could no	28e Place	of Injury - At he	ome, farm, street,	factory, office bu	ilding, etc.	28			and Number	or Rura	Route Number, City
Dipital ours a filled	Certification:	4 V Homicide determin	ned (Specify)	Local Stree	et			10	or Town 58 West I	_exingto	n Street, E	Baltimo	re, MD
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bu		29a. Certifier (Check only one) 2 Medical Examir	ician: To the best										
To th To th	Medical	29b. Signature and title of certifier	and manner sta	ted.	- Ind/Of Trivestigation	29c. License		eu at ii	ie time, dat				
	-	A TOTAL	11 .1 .	1		O.C.M					v 7, 2010		h, Day, Year)
		ramely) 411	Tall Mil	1	22-1	J.C.IV				ivia	, , 2010		
		30. Name and address of person when Pamela E. Southall, MD			-	Penn Street,	Baltimore	e, MD	21201				
S	ate	31. Date filed (Month, Day, Year)		istrar's Signat									
Regis	trar	MAY 1 1 201	W Kense	a p.	me face				_		/35.00		
											UUIVII		

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	Maryland /	-	artment of H tificate of L			Reg. No.	010	14579
	Physicia		Decedent's Name (First, Middle Bernice	, Last) Eve	lvn		Bass		2. Date of 1 Month May	Death Day	2010	3. Time of Death 4:15 P
	/Medic		4a. Facility Name (If not institution				4b. City, Town, or	Location of I			County of Deal	
	Examin	er	415 Russell Av		•		Gait	hersbu	ırg		Montg	omery
	Funeral Director		5. Social Security Number 461–20–8343		. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of (Month, June	Birth Day , $Year$)	9. Bird	thplace (State or Foreig ountry) Texas
	DQ *		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation					10d. Inside City Limits
	Aaryle reho	ŏ	MD Montg	omerv			Gaithers	burg				1 ☐ Yes 2 🙀 No
	28a-1	rect	10e. Street and Number	Omery			10f. Zip Code	5418		10g. Citi	zen of What Co	ountry?
	3a or	0	415 Russell	Ave. #606			2	0877		U	nited S	states
3	be filed within 72 hours after death with the Maryland tial Hygiene. And other than "naturel", or Itams 23a or 28a-f show event, it e Medical Evaninar must be ricitified at	by Funeral Director	11. Marital Status 1 Never Married *** Married *** Married *** Married *** Noticed *** No	Armed Ford	2 X No		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origin, Mexican, I	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ame Black, Whit Specify:	
Mai yiaiid E1E19-000	C * W	Completed	15. Deceden (Specify only higher	's Education	1	(Give life.	dent's Usual Occup kind of work done o DO NOT use retired	lurina most c	of working		nd of Business	
7	filed with Hygiene. Ither than	E O	Elementary/Geservatry (G-12)	4		Но	memaker				Own Hom	ie
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<u> </u>	ls ar		19a. Informant's Name/Relations James P. Bass				Russell A					
	is 1 and 2 should of Health and Men Item 27 Is marke other traumatic		20a. Method of Disposition	,	20b. Plac	e of Dispo	sition (Name of		Date		ocation - City or	
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Daltilliole,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service	-	M00382	2 2: R	2. Name and Address app Funer	s of Facility	d Cremati	on Se	rvices	20910
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on ea	ch line.	Do not en	ter the mode of dyin	g, such as c	ardiac or respirator			Approximate Interval Between Onset and Death
,007	icate be exacuted was physician and purial-transit and	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	S c	or as a consequen	gas nce of):	iree ig	mp	ioma			
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VII	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hoenital:			04		of Death (Check or	/		
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2	i Pire	I Certif	4 Homicide deterr	buildin	ng, etc. (Specify)	edge dea	th occurred at the ti	ne date and	City or	Town, State	e) and manner	as stated.
1	24 hc 24 hc Fun etely i	Medical	(Check only 2 Medice	Exeminer: On the ba	sis of examination	n and/or i	nvestigation, in my	ppinion, death	h occurred at the ti	me, date an	d place, and du	ue to the cause(s)
A I	To the Hospital within 24 hours a To the Funerel completely filled	Me	29b. Signature and title of certific	er .	л	Msh	29c. Licens				ate signed (Moi	
		á	30. Name and address of persor	who completed cause		انتو (Type) (Type)	Print) AUE G1	+14HE1	essueci	MB	2087	7
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10a-f per inf g905 7-1-10-vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 6, Year Robert Pulaski Bird, Jr. 20 TO 8:00 a.mM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Glorious Care Nursing Center Damascus Montgomery 9. Birthplace (State or Foreign Country)
Ohio If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, You Hours Months 1 🔀 M 2 🗆 Director 290-14-0963 87 Yrs. Nov. Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Brevard Melbourne -Damascus 1 Yes 2 K No Florida 10e. Street and Number 3631 Turtlemound Rd. 10f. Zip Code 10g. Citizen of What Country? 32934 Funeral 10409 Sweepstakes 20872 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ⚠ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates. White Specify: Completed 3 Widowed 4 X Divorced WW II 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Admin<u>istrator</u> Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Pulaski Bird. Sallie Sr. Be11 Spooner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24712 Showbarn Cir., Damascus, Robert P. Bird, III/ Son MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
Burial 2 Cremation 3 Removal from State 4

▼ Donation 5 □ Other (Specify) Science Care 5/7/2010 Aurora, CO 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 Signature of Funeral Ser M00382 The Avolument 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ EREBROYASCULAR CIDENT disease or condition resulting in death) 14 019 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence oi). Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit NOROME that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death 2 🗌 No 9 Unknown 9 Unknown Records, P.O. signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tes within 2 hours after death.

To the Funeral Director. After this certificate has been significant completed filled in by the funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be examiner? LOWGE TERCH 2 X No Other: 4 \square Nursing Home 5 \square Residence 6 Other (Specify) CARE FACILITY မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 🗆 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00005510 MONTGOMERY VILLAGE, 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 2088 BALNATH Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05 Physician/ 1735 PM Brian 2010 TOWA Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 1) 5. Social Security Number . Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Year) 968 1X M 2 □ 212-96-1518 41 MD **Director** Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland notified at Director 1 🗌 Yes 2 🌠 No MD Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a or edical Examiner must be Funeral 1160 Hayman Drive 21032 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 24 No 1 Never Married 2 Married ð Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: White Completed 3 Widowed 4X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Store Manager Grocery Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Donald H. Brown Patricia L. Pistorio permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr Donald H. Brown/ Father 775 Barger Drive Crownsville, MD 21032 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 10, 1 Burial 2 Cremation 3 Removal from State 2010 4 Donation 5 Other (Specify) Meadowridge Mem.Park Elkridge, MD 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between n t a d Death Immediate Cause (Final Physician/ 190 Ca val disease or condition Medical resulting in death) Due to o as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) 9 Unknown P.O. ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I by 2 No 3 Probably 4 Unknown Records, 1 🗌 Yes been signal Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 M DOA ျ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 Matural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 □ only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

			For State Registrar	State of M	laryland / De C	partment o ertificate				giene Reg. No.	010	14582
	Dhusini		1. Decedent's Name (First, Middle, Las		7.	1	10		2. Date of De		Year	3. Time of Death
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	Examin	er	4a. Facility Name (If not institution, give				wn, or Location				County of Death	
		ļ.	HARFORD MET			HAVA If Under 1	_	ler 24 Hrs.			larford	
	Funeral		5. Social Security Number 6. S	ex [\$20M 2□F 7.A/	ge (In yrs. last birthda 76 Yrs.	Months [ays Hour		8. Date of Bir (Month, Da	th v. Year)	9. Birth Cou	place (State or Foreign ntry) 1 and
	Director		215-32-6363 Usual Residence of Decedent		70			1 1	Jec. Z.	, 13	33 mary	Land
	land		10a. State 10b. County		10c. City, Town or	Location						10d. Inside City Limits
	Man	tor	Maryland Harford	E	Aber	deen						1 ☐ Yes 2 🛣 No
	r 282	Director	10e. Street and Number		-1	10f. Zip C	ode			10g. Citi	zen of What Cou	intry?
	h wit	ai D	1902 Park Beach	Drive		210	001			Unit	ed State	es
	within 72 hours after deeth with the Maryland ene. than "natural", or iteme 23a or 28a-f ahow than "Natical Examanar must be coulled at	Funerai	11. Marital Status	12. Was Decedent Armed Forces	t Ever in U.S. 1	3. Was Deceder If Yes, specify	t of Hispanic	Origin? (Spe	cify Yes or No)-	14. Race - Ameri Black, White,	
9	or its	/Fu	1 ☐ Never Married 2 ☐ Married	1 Yes 2 If Yes, Give	No	1 Tes 25			noari, oto.)		Specify: Wh:	
21215-0036	ural',	Completed by	3 Widowed 4 Divorced	Year or Dates:			•				Specify. Wil.	
Ϋ́	nat	lete	15. Decedent's Ed (Specify only highest gra		16a. De	cedent's Usual (ive kind of work of a. DO NOT use	Occupation done during m	nost of workin	ng	16b. Ki	nd of Business/Ir	ndustry
7	than this	ш	Elementary/Secondary (0-12)	College (1-4or	5+)	te Troop				T.aw	Enforce	ment
2	Hygie ther nt.		17. Father's Name (First, Middle, Last)		bea			ther's Name	(First, Middle			ikerre
Maryland	od be	Be c	Eldon L. Budnic					elma S:		, maioon	oumanno,	
<u></u>	houle d Me mark matic	၉	19a. Informant's Name/Relationship (19h Ma	ailing Address (S				er City o	r Town, State, Zi	n Code)
E S	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Menial Hygiene. Department of Health and Menial Hygiene. Integrate if items 23a or 28a-f ahow mary injury or other traumatic avent. It a Medical Example must be confilled at once.		Nancy J. Budnick			2 Park I						
ē,	Hear tem		20a. Method of Disposition	,	20b. Place of Dis	sposition (Name	of	D	ate		cation - City or T	
9	Page ent o nt: #		1 ☐ Burial 2√C Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif				hapel	May 1	1,	Daves		Marriand
Baltimore,	ortain inju		21. Signatura of Funeral Service Licer		Bel A		Address of Fa	cility 201	10	FOLE	SC HIII	, Maryland
ä	99 1 9		I fav & Cho	aux		Evans Fi 3 Newboi	ınera⊥ rt Driv	Cnape. e Fore	ı & Cre est Hil	emati 1. M	on Servi Marvland	ices-BelAir 21050
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	the death certification is the attending partner as the attending partner as as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death	3 □Ectopic preg 5 □ Other (spec					23d. Date of delik	very Day Year
ις.	w requires that s been signed b should be deta		Part II. Other significant conditions of			underlying cau	se given in Pa	art I.	23e. Did	tobacco u	use contribute to	the cause of death?
ĕ	quire an sig	edt	DIARGIES ME	CLITUS	CORENA	MY ALG	TORY 1	11EAR	} 1□	Yes 2	□No 3□Pro	bably 4 Unknown
Reco	he law re e has be age 2 sho	Completed by			TAINS	LANSA	TION	For	24a. Was auto perfe		prior to a	opsy findings available ompletion of cause of
<u>a</u>	tifice tor. p	0	25. Was case referred to medical	MILLING			26 PI	ace of Death	Check only	-	1 Yes	2L No
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0	g Ph ter th		27. Manner of Death	28a. Date of Inj (Month, D			. Injury at Work?		28d. Describe			
<u>ö</u>	eath. or: Af	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	n	ay / Gary Infor	, м	1 ☐ Yes 2	□No				
Division of	To the Hospital or Attending Physicien: The I within 24 burs elected each. To the Funerel Director: After this certificate he completely filled in by the funeral director. page	Certification:	3 Suicide 6 Could not b 4 Homicide determined	286. Place of it	njury - At home, farm, atc. <i>(Specify)</i>	street, factory, o	office	2	28f. Location (City or To	Street an wn, State	nd Number or Ru n)	ral Route Number,
	To the Hospital or within 24 hours efte To the Funerel Directional Completely filled in It	Medicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	nysician: To the bes niner: On the basis and manners	t of my knowledge, do of examination and/o tated.	eath occurred at r investigation, in	the time, date my opinion,	and place, a death occurre	and due to the ed at the time,	cause(s) date and) and manner as d place, and due	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			1 1	icense numb				te signed (Month	
			My She			0	213	58		17A7	7.09-	2010
_	15		30. Name and oddress of person who ALAN SUEAT	completed cause of	death (Item 23a) (Tyl	oe, Print)	e14c	H050	TTL.	HA	UNG 00	GRACE.
	Sta		31. Date filed (Month, Day, Year)	32. Regis	trar's Signature							

MAY 11 2010 Lenun S. Santi

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2010 05 **Physician** NORA PATRICIA BAKER 02 4:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7826 Bodkin View Drive Pasadena Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 ■ F 217 24 5319 82 Yrs. Director 04/08/1928 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Experiment must be notified at **Funeral Director** 1 ☐ Yes 2 No MD Anne Arundel Pasadena the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7826 Bodkin View Drive 21122 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or iter 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 No à Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accountant State Budgeting 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be Edward William Wolff ္ရ Molly McHale 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 is any Injury or other trau George J. Baker - husband 7826 Bodkin View Dr. Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/6/2010 | Baltimore, MD Holy Cross Cem 22. Name and Address of Facility GJ Gonce Funeral Home 21. Signature of Funeral Service Licensee Dr. Pasadena, MD Riviera 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 04 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 2015 once. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760 Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 Other (specify) s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ Completed 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 s autopsy 1 ☐ Yes 2 ☐ No 1 □Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner 1 Yes 2 No Hospital: Other: 4 \sum Nursing Home Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 20/0 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Physician /Medical Examiner Funeral Director	1. Decedent's Nam	ne (First, Middle				rtificate	of l	Death	7		Reg. No.	UIU	1 9 0 0 7
Funeral		LEKI	A A	131	AC					2. Date of D Month	Peath Day	201	3. Time of Death 8 0 5 PM
Director	4a. Facility Name CY29U 5. Social Security 218-58-5	WELL Number	6. Sex 1 M 2 F	. Age (In yrs.	last birthday,	If Under 1	tin	nore	of Death	8. Date of B	irth	Baltin 9. Bi	
yland iow	Usual Residence of			58	y, Town or L	ocation				Dec 0	2, 195	01 20	10d. Inside City Limits
after death with the Maryland or Items 23a or 28a-f show miner must be notified at Moreral Director	Md .			В	Baltimo	ore 10f. Zip C					10g. Citiz	en of What C	•
xa Q	11. Marital Status 1 □ Never Mar	mge Roa	12. Was Deced		.S. 13.	Was Deceder If Yes, specify		ispanic C an, Mexic		ecify Yes or N Rican, etc.)		Black, Wh	erican Indian,
nt, the Medical E	Elementary/Sec		's Education of grade completed) College (1-4	4or 5+)	16a. Dece (Give life. Bake)	edent's Usual (e kind of work DO NOT use	Occupa done o retirea	ation during mo	est of worki	ing	1	d of Business	s/Industry
atic event,	17. Father's Name James	(First, Middle, Black,	,						ner's Name dna	Britt		Surname)	
ther traum	19a. Informant's NMr. Jess	e Black	nip (Type. Print) / Brother	20h E	1083	ing Address (S	low1	lea F	Rd. 0		Mills,	, Md. :	21117
any injury or or once,	1 Burial 2	Cremation 5 ☐ Other (Sp			1top S	osition (Name ematory or oth Service 2. Name and	e Co).	5-8-1	10	To	owson,	
been signed by the attending physician and should be detached for use as the burial-transit should be detached for use as the burial-transit should be detached for use as the burial-transit should be detached by Physician/Medical Examiner	Sequentially list of any, leading to cause. Enter Und Cause (Disease of that initiated event resulting in death)	onditions, minediate erlying r injury	b. Due to (o	r as a consequence of the conseq	uence of): U uence or): U uence of):	SEV N {		si en		HCATION APPR	(MED BY M	EDICAL EXAM	2481 WEEK
letached for use as the but th	IF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknow	2 months? □ No		th 2 □ Feta nt at time of d	ıl death 3	□Ectopic preg □ Other (spec					2:	3d. Date of d Month	elivery Day Year
should be deta	Part II. Other sign	ificant condition	ons contributing to dea	th but not resi	ulting in the u	underlying cau	se give	en in Parl	: I.				to the cause of death? Probably 4 □Unknow
S S O	25. Was case refe	rend to estadical								per 1∐ Yes	opsy formed? 2 □ No	death?	autopsy findings available completion of cause of s
After this uneral d on: To	examiner? 1 Yes 2	TNo-	28a. Date of (Month) ation of be 28e. Place o	Injury , <i>Day Year)</i>	28b. Time of Injury	nt 3 DOA of 28c M ereet, factory, c		er: 4 🗗 1	ursing Ho	me 5 Res 28d. Describe 28f. Location City or To	sidence 6 how injury	occurred Number or i	ecify) Rural Route Number,
within 24 hours after death. To the Funeral Director: v completely filled in by the f Medical Certificati	29a. Certifier (Check only one) 29b. Signature and	2∐ Medical I	g Physician: To the base and manner	sis of examina	wiedge, dea tion and/or i	nvestigation, ir	n my o	ne, date a	eath occur	and due to th red at the time	e, date and	place, and d	as stated. ue to the cause(s)
	30. Name and add		who completed cause	of death (Item	1 23a) (Type	Print) &	715	27	17 = hc	OE "	09 NS	107	12010 HUTIMALE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Month Day 8:30 P S. Brennan 5 201⁶ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Baltimore Timonium Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours Min. 256-20-1982 90 Georgia Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Baltimore Reisterstown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral 21136 2 Quail Cross Court U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", 3 🛛 Widowed 4 🗆 Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Medical Nurse Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental item 27 is marked ည Susan Keane James Sheehan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 707 | aurellane Wayne. Pennsylvania 19087 19a. Informant's Name/Relationship (Type, Print) 707 LaurelLane Wayne, Pennsylvania Thomas Brennan / Son Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
New Cathedral Cemetery 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1 🛛 Burial 2 🗌 Cremation 3 🗌 Removal from State 5/10/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral 5 elLe Liceu 22. Name and Address of Facility Ruck TowsonFuneral Home, Inc. 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans. that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) ☐ Yes 2 ☐ No 9 🗖 Unknown 9 Unknown of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 Yes 2 No BRENNAN Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of ceath (Item 23a) (Type, Print) CRNP 2300 DULANEY VALLEY ROAD JENNIFER HAUF, TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. R

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Day **Physician** 7:15 AM KAZIMIERA BOGDAN 2010 MAY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE 307 FOLCROFT STREET 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Funeral Min 1 □ M 2 🔀 F Months Days Hours POLAND 11/10/1921 Director 218-48-2673 88 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, I'm Medical Evantimer mast be notified at 1X Yes 2 No Director BALTIMORE MD. N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UNITED STATES 307 FOLCROFT STREET 21224 Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ 3 Wildowed 4 □ Divorced WHITE Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) TAILOR SEAMSTRESS 8TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be WERONIKA KAMINSKA WLADYSLAWA KOLODZIEJSKA ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health an Important: If item 27 is any injury or other trau TERESA STURGILL/DAUGHTER 307 FOLCROFT STREET, BALTIMORE, MARYLAND 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State SACRED HEART OF JESUS MAY 10, 2010 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) neral Service Licensee 21. Signat 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. re of Fu 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 P 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s ock, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Peath I meriate Cause (Final di ese or condition resulting in death) minutes acrtic **Physician** NO hable /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Box 68760 Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month 5 ☐ Other (specify) P.0. signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ oronary 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □ Other (Specify) Certification: To this after death.

I Director: After this id in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 ☐ Homicide within 24 hours a

To the Funeral Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Bayview, Baltimore State Registrar

DHMH 17 Rev 1/2001

10-03223 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Michael Neal Cornell State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Day April 26, 2010 **Medical Examiner** Michael Neal Cornell 1238 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 7144 Lasting Light Way Columbia Howard 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Months Hours 277-54-4568 1 M 2 F 54 Country) Ohio July 7, 1955 Usual Residence of Decedent any 10a. State 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 X No Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f short or other traumatic event, the Medical Examiner must be notified at once or items 23a or 28a-f sho must be notified at once. Maryland Howard Columbia rector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7144 Lasting Light Way 21045 U.S.A. Funeral 11 Maritat Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 No Yes 3 Widowed 4 Divorced Yes, Give Year 1 Yes 2 X No specify: White Specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Pharmaceutical Sales Representative Johnson & Johnson 17. Father's Name (First, Middle, Last) 1B.Mother's Name (First, Middle, Maiden Surname) Gerald B. Cornell, Sr. Joan L. Wickline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Cornell (Mother) 103 Oak Hill Avenue Delaware, Ohio 43015 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery 1 Burial 2 X Cremation 3 Removal from State crematory or other place) Important: Atlantic Crematory 4-29-2010 Glen Burnie, Maryland 4 Donation 5 Other Specify 21. Signature of Funeral Service Lie 22. Name and Address of Facility Witzke Funeral Hoimes, Inc. 5555 Twin Knolls Road Columbie, Maryland 21045 Physician Part I Enter the digease or co ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and /Medical Death Immediate Cause (Final disease Alcoholis Ketoacidosis Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last attending physician and or use as the bunal - transit The law requires that the death certificate be executed Physician/Medical X UNPENDED AMENDED 27.perm.E g903 5/17/10 TT Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Year Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 V Unknown Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed? death? 1 ✓ Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be Other Nursing Home 5 Residence 6 🗸 Other: Scene Inpatient ER/Outpatient 3 DOA this 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) After 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending 1 Yes 2 No 24 hours after death Director; filled in by the 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical within 2 To the I 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

DHMH 17 Rev 1/2001

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State Registra

32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Carol Allan, MD

Md

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

April 27, 2010

and manner stated

Assistant Medical Examiner

alla

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Zandra Irene Coale 9:30 May 5, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Wilson Healthcare Center Gaithersburg Montgomery Birthplace (State or Foreign Country) A 7. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Months Days 1 M 265xF 89 Hours Min. 3 /247 192 Year) AZ Director 557-20-8614 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "name" any injury or other transmitters. 10c. City. Town or Location 10a State 10h Counts 10d. Inside City Limits **Funeral Director** MD Gaithersburg 1 ☐ Yes 2√No Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 401 Russell Ave. 20877 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married Completed by 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Public Elementary/Secondary (0-12) College (1-4or 5+) school Administrator Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be ပ Urban James Lewis Mary Rozen 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allen Coale, husband 401 Russell Ave #212 Gaithersburg, MD 20877 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 5/7/2010 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only Onset and Deat Immediate Cause (Final disease or condition resulting in death) Onewick **Physician** /Medical **Examiner** heimer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 ☐ Unknown 9 Unknown Part II. Other significant conditions, contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 itension. Osteanorosis 1 | Yes 2 | No 3 | Probably 4 | Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed minence 2 🗆 No 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending within 24 hours arter occurred to the Funeral Director; Aff investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number ٩ 29d. Date signed (Month, Day, Year) V. Robert Direchbach use 04165 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IL ROBERT BIRSC HBACH, WID 31. Date filed (Month, Day, Year) 32. Registrar's Signatu

Registrar

State

Box 68760.

Division of Vital Records, P.O.

Amend #8 per Fh g903 5/11/10 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Physician 12.45 P M Corbitt Helena 04 30 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Future Care-Charles/Homewood Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. | 8. Date of Birth 1/27/1930. Birthplace (State or Foreign (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X 79 New Jersev Director 157-22-5427 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State If item 27 is marked other than "natural", or items 23a or 28a-f shot or other traumatic event, the Medical Examiner must be notified at Y Yes 2 No Director Baltimore Md. N/A10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2618 Huron Street 21230 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ZMo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: 3 ☐ Widowed 4 ☐ Divorced **Black** Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 721 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be fit Department of Health and Mental Hy Important: If item Z7 is marked oth, any injury or other trainments. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Lee Pease Wardell Pease 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Josette Simms 549 Half Mile Court, Baltimore, Md. 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial ★★Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/6/2010 | Catonsville, Md. Metro Crematory 21. Signalur of Free eral Service Licensee Estep Brothers Funeral Service, PA 1300 Eutaw Place, Baltimore, Md. 21217 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each the. Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner annie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit Exami Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Maemie Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) I Yes 2 □ No the 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe within 24 hours a er death.

To the Funeral Director: At er this certificate I completely filled in by the fureral director, page 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ ₩6 Be 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Hatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHOAIB Street Ente 308 BALTIMORE M17 2126 ·HA SHMI 821 N. Evtur A MD Date filed (Month, Day, Year) 32. Registar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Marquise 2:13 AM Malachi Collins 2010 /Medical Mar 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore Medical Contor Freater 00 Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Months Year) Days Hours Director 05/19/2005 MARULAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla administration of Health and Mental Hygiene. ordant: If Ifem 23 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Exp. 1 we must be multilated. COCKEYSVILLE 1 □Yes 2 No Director Collins, Marquise 10e. Street and Number 10g. Citizen of What Country? CIRCLE U.S.A 21030 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Never Married 2 Married 3 Widowed 4 Divorced 1 ☐Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: BLACK Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry NONE NONE Elementary/Secondary (0-12) College (1-4or 5+) 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RussEll Collins TERMARRA ပ္ VUONNA 19a. Informant's Name/Relationship (Type. Print) FATheR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21030 permit. Pages 1 and 2 to Department of Health at Important: If item 27 is any injury or other trau 104 HOGARTH CR. COCKEYS UITE MARY And ace of Disposition (Name of Date 20c. Location - City or Fown, State RUSSEII COLLINS JA EARL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State KING MEM. PK. CEME 1/4/2010 BALTIMERE, MARYIMEN 22. Name and Address of Facility The DERRICK C. JONES FIH, P.A. 14/2010 BALTIMORE, MARYIAND 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Censee 4611 PARK HOTS. AVE. , BALTIMORE, MARYIAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ap oximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dilated Cardiomyopathy /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) P.0. signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 2 X No Division of Vital 1 ☐ Yes 2 No 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3 □ DOA this After this funeral d 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MD

Steinberg

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GBMC

32. Registrar's Signature

Pediatrics

29c. License number

D0067520

6701 N Charles St

29d. Date signed (Month, Day, Year)

5/5/2010

Baltimore, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Gustav Joseph Crespo Month 12:00 PM May 8 2010 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 24 Bouton Green Court Baltimore Date of bit. (Month, Day, Year, Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)
Puerto Rico 064-12-3033 1 X M 2 D F Months Days Hours Min 90 Yrs Director 192b Usual Residence of Decedent f show 10a. State 10b. County "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21210 Funeral 24 Bouton Green Court with USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, ed Forces? Black, White, etc. þ 1 Never Married 2 X Married X Yes Baltimore, Maryland 21215-0036 1 Yes 2 □ No Specify: Puerto Rican If Yes, Give US Navy Year or Dates US Navy White Specify: 3 Widowed 4 Divorced Completed er than "natur , the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 7 ment of Health and Mental Hygiene. tant: If item 27 is marked other thar lury or other traumatic event, the M College (1-4 or 5+) Elementary/Seconday (0-12) Sales/Office Equipment Salesman 12 5+ 18. Mother's Name (First, Middle, Maiden Surname)

Margaret (unkn) Be 17. Father's Name (First, Middle, Last) 2 Armand Crespo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 24 Bouton Green Court, Baltimore, MD 21210 Ilene S. Frame / Wife permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th once. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1
Burial 2 Cremation 3 Removal from State Final Journey Crem. 5/11/2010 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility Maryland Cremation Servi PO Box 1413, Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition 101 rears Medical resulting in death) Due to (or as a consequence f) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and the burial-trar Due to (or as a consequence of): resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? this certificate 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 10 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) nours after death.

neral Director: After the filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) the Hospital thin 24 hours a the Funeral D Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Mary DOO 5194 10, 2010 Lamos address of person who completed cause of death (Item 23a) (Type, Print) regulspep Falls Road 22F01 31. Date filed (Mohth, Day, State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2010 Crawford Melanie Ruth /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NSCX Home Medical Center Birthplace (State or Foreign Country) Year 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🗓 F Director 217-40-4509 67 May 8, 1942 Maryland Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State 28a-f show 1 ☐ Yes 2 X No Director Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Item 27 is marked other than "natural", or items 23a or other traumatic event, it a fredical Example in the live of the control of the contro 8 Belmullet Court, #202 21093 USA 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No !f Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married timore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 2 Q Specify. 3 ☐ Widowed 4 🕅 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 01 Marketing Representative Banking win z should be fil. If Health and Mental Hy tem 27 Is market 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ The 1ma Pages 1 and 2 should Bergstrom Andersen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Elphin Court, #301, Timonium, Maryland 21093 Jennifer Ann Crawford/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ŏ ō 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Important: If any injury or once. 4 ☐ Demation 5 ☐ Other (Specify) Parkwood Cemetery 5/8/10 Parkville, Maryland Bryan W. Clary 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, Maryland 21093 23a. Part 1. F ter t e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heat failure. List only on caus on each line. Immediate Cause (Final disease or condition resulting in Hamm) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examiner anding physician and use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy Month Day 5 Other (specify) After this certificate has been signed by the stuneral director, page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ☐ Yes 2 ₺No 2 12 No 1 □Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🛘 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

To the Hospital or Attendin, within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Signature and title of cetitifier Smalla My

29b. Signature and title of certifier

29c. License number 20051347 29d. Date signed (Month, Day, Year) 5/6/10

Oriano, MO 670; N. Charles St Ballinove MO 21204 32. Registrar's Signature

Ph/

State Registrar 30. Name and address of

31. Date filed (Month, Day, Year)

JUSTIN CHRONISTER

d cause of death (Item 23a) (Type, Print)

DO

BES-000

4940 EASTERN AVENUE BALTIMORE, MO 21224

01,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	tate of Marylanc		irtment of F tificate of D			ene g. No. 201	0 14594
	Physicia		1. Decedent's Name (First, Middle, Last) Evelyn L.	Coulthar	·d			2. Date of Death		3. Time of Death 1:50 а м
	Medic Examin		4a. Facility Name (if not institution, give street 48 Clubview Lane	and number)	·	4b. City, Town, or Phoer	Location of Death	<u>. </u>	4c. County of De	imore
	Funeral		5. Social Security Number 212-03-9668 6. Sex	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	9. E	Birthplace (State or Foreign Country)
	Director	L	Usual Residence of Decedent 10a, State 10b, County		Town or Loc	ration		Jan. /,_	1914 [Da	10d. Inside City Limits
	Marylan 28a-f sh otified a	Director	Maryland Baltimore	Phoe						1 ☐ Yes 2 🔀 No
	with the 23a or	Funeral D	10e. Street and Number 48 Clubview Lane			10f. Zip Code 21131		10	g. Citizen of What (U.S.A.	Country?
980	ge 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If fiem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 1	/as Decedent Ever in U.S. rmed Forces? ☐ Yes 2 → No Yes, Give ear or Dates.	If	√as Decedent of Hi Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify: Wh	
215-0	72 hou an "natu Medical	Completed	15. Decedent's Education (Specify only highest grade continuous Con		(Give k	ent's Usual Occupa ind of work done of NOT use retired)	ation luring most of worki	ng	6b. Kind of Busines	
Maryland 21215-0036	ould be filed within 7: Ind Mental Hygiene. marked other than matic event, the Me	Be Co	12 17. Father's Name (First, Middle, Last)	Jilege (1-4 0/ 3+)	Secre	etary	18. Mother's Name	F e (First, Middle, Ma	ederal Go	overnment
ylan	uld be fil I Mental narked natic ev	2	Gabriel William Cost				Mabel Ar	rmstrong		
, Mai	and 2 should Health and Me Iem 27 is mar other traumati		19a. Informant's Name/Relationship (Type, Pr Susan DiNenna/ daugh	·			and Number or Rura ane, Phoe		City or Town, State, .	Zip Code)
Baltimore,	permit. Page 1 an Department of He Important: If iten any injury or oth once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remode 4 ☐ Donation 5 ☐ Other (Specify)	wal from State Cel	metery, crem Holy	sition (Name of natory or other plac Redeemer	May 1		Oc. Location - City Baltimore	· ·
Balt	permit Depart Import any inj once.		21. Signature of Funeral Service Licensee			Name and Addres	Rd., Tow	ck Towson	n Funeral 21204	Home, Inc.
	nysician/ Medical Examiner	,	23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	se y each line. Due to (oy is a conseque	e Hea	rthe mode of dying urt F Hery	g, such as cardiac of a lure Disea		t,	Approximate Interval Between Onset and Death
2 092	cate be executed physician and the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	F	brill Vascul	ation an Dis	ease/		
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate that bours after death. Within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Ž	in the past 12 months?	yes, outcome of pregnand Live Birth 2 Fetal Pregnant at time of de	death 3	Ectopic pregnanc	у		23d. Date of o	delivery Day Year
s, P.O	uires that th signed by Id be deta	by	Part II. Other significant conditions contributions Hyper Fen Siov	ting to death but not resul	lting in the u	nderlying cause giv	ven in Part I.	23e. Did toba		to the cause of death? Probably 4 🗆 Unknown
Division of Vital Records, P.O.	rsician: The law reques certificate has bee lirector, page 2 shou	Completed	Hypercholeste	rolemia	rse_	· <u> </u>		24a. Was an autopsy perform	prior t	autopsy findings available o completion of cause of ? /es 2 \(\sum \) No
/ital	sician:	To Be (25. Was case referred to medical examiner? 1 Yes 2 No Hospit	al:	R/Outnatien	Othe	ace of Death (Checker:	only one)	ice 6 Other (Sp	ación Hospica.
n of \	ding Phy h. After this funeral o		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		28b. Time of injury	28c. Injury work	/ at	28d. Describe how		55117/
ivisio	I or Atten after deat Director: I in by the	Certificate:	3 Suicide 6 Could not be	Be. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre			28f. Location (Stre City or Town,		Rural Route Number,
	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Medical			and/or invest	igation, in my opinic	on, death occurred at	the time, date and	place, and due to th	e cause(s) and manner stated.
	To the virthing to the control of th		29b. Signature and title of certifier	and MO	MPH	29c. License	17-417	29	d. Date signed (Mo	nth, Day, Year)
	10		30. Name and address of person who comple SHARON DLHOSO	ted cause of death (Item 2	23a) (Type, P		Josepa Ca	nesules.	Lothery	ille Md. 21093
	Stat Registra		31. Date filed (Month, Day, Year) MAY 1 1 201	32. Registrar's Signatu	A.	ball	, ,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 6:10 PM Sarah Collins 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CENTER SAINT JUSEPH TOWSON MEDICAL BALTIMORE If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🏝 F Hours 7/26/1918 Ire Tand Director 213-30-9713 Usual Residence of Decedent 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Maryland Baltimore Towson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 524 E. Seminary Ave. 21286 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 XNo . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ŏ þ 1 X Never Married 2 Married 1 Yes Maryland 21215-0036 1 Yes 2XXNo Specify: "natural". Completed Specify: White 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. sant: If item 27 is marked other than ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Caretaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Collins Mary Hore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 524 E. Seminary Ave. Towson, Maryland 21286 Anna Von Lunz / Guardian Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Druid Ridge Cemetery 20c. Location - City or Town, State 5/13/2010 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State Important: It any injury or Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Mary land 21204 Signature of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician INFARCTION MYOCARDIAL Medical resulting in death) Due to (or as a consequence of) Examiner I hour Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No 4 Pregnant Dav Pregnant at time of death is certificate has been signed by the director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No CONGESTIVE HEART 24a. Was an autopsy After this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral dir Certificate: To 1 Na Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 2 ☐ Accider 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 82 30. Name and address of person who completed cause of death (Jem 23a) (Type, Print) EBELING m.D. DRIVE MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Pojistar's Signatur State

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #17 & 18 per AB g903 5/11/10 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** CHATMAN 3,2010 9:30 /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death Examiner ROCKVILLE
If Under 1 Year | If Under 24 Hrs.
Page | Hours | Min. SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY 8. Date of Birth (Month, Day, Yes April 21, Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 2010 1⊠M 2□F Months INFANT Director 30 April Maryland Usual Residence of Decedent 10a. State 10b. County unk 10c. City, Town or Location 10d Inside City Limits show ltem 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, in a theorical Examiner must be nothered at 1 ☐ Yes 2 No Director SC Manning 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29102 USA 1219 Meagan Lane Funeral death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hyglene.
ant: If Item 27 Is marked other than "natural", or ite 1 ₩ Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: black Completed by 3 Widowed 4 Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) INFANT College (1-4or 5+) INFANT INFANT INFANT 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be Chaniece Williams ဥ Chaniece Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chaniece Williams/mother 1219 Meagan Lane; Manning, South Carolina 29102 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If Ite
any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4□Donation 5X1Other (Specity) in state 21. Signature of Funeral Sarvio 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Director 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate base (Final disease or condition resulting in death)

a. Respiratory distress Syndrome Approximate Interval Between Onset and Death **Physician** /Medical Due to (of as a consequence of Examiner Extreme if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) s been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy The performed 1 ☐ Yes 2 No Division of Vital spital or Attending Phystclan: Theores after death.
neral Director: After this certificate y filled in by the funeral director, pa 1 □ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C Hospital CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death accurred at it. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ertifie 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and itle 30. Name an idress of person who completed cause of death (Item 23a) (Type, Print) Drive, Rockville 9901 Medical 20850 Jan Kos 31. Date filed (Month, Day, Year) 32. Registra's Signature State

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#8, perFH, G904, 6/8/2010, WS
State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mont Physician/ 20ÎÖ Catherine Palmer Deets 3:35 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Columbia Somerford Place Assisted Living If Under 1 Year If Under 24 Hrs 8. Date of Birth 2-13-1920 Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1 M 2 X F Months Hours Pennsylvania Director 219-01-2621 90 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director Maryland Clarksville 1 Yes 2 X No Howard 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21029 7208 Guilford Road U.S.A. 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Bace - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc. þ 1 Never Married 2 Married Yes 2 x No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: Specify: 3 X Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be fili Department of Health and Mental | Important: If item 27 is marked c any injury or other traumatic eve 0 Vera Grace Brittingham Chester A. Palmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7208 Guilford Road Clarksville, Maryland 21029 Cynthia Kupres (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔲 Burial 2 🙀 Cremation 3 🗆 Removal from State Atlantic Crematory 5-4-2010 Glen Burnie, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Servi Witzke runeral Hoimes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph, sician/ estiva disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a conse To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlar-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) assisted Hospital 2 No ၉ 1 Tes living 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury Natura 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title o 29c. License number 29d. Date signed (Month, Day, Year, 0 63764 MD persod who completed cause of death (Item 23a) (Type, Print) 30. Name and address of ١O Dr. Mohammed Mehboob 7070 Samuel Morse Drive Columbia, Maryland 21046 31. Date filed (Month, Bay, Year) 32. Reg rar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 10.45PM Sylvester W. Dunn MA 2010 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORG HOSPITAL AGNES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 24, 1943 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 AM 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Days Hours Months. Maryland Aug. 214-40-6783 66 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f shov "natural", or items 23a or 28a-f sho 1 ☐ Yes 2√ No Director Catonsville MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 United States 4917 Wilkens Ave. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any Injury or other traumatic event, Item Medical English Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Beauty Industry Elementary/Secondary (0-12) College (1-4or 5+) Barber 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Krottee Margaret Sylvester Ruth Dunn ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Viola Dunn/ Wife Wilkens Ave. Catonsville, Maryland 21228 4917 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State May 9 ,2010 Glen Burnie, Maryland Atlantic crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service License 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. tature or El 1328 Sulphur Spring RD. Arbutus, MD. 21227 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final CARCINOMA OF **Physician** G MIDHTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner burial-trar Due to (or as a consequence of) Box 68760, nding physiclan that the death certificate be Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Year Month 5 ☐ Other (specify) ☐Yes 2☐No ned by the a detached f Ö 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, **S** Hospital or Attending Physician; The law requires to hours a let death. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2/2/No 2 🗆 No 1 □ Yes 1 🗆 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2☑No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred .1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely f and manner stated 29d. Date signed (Month, Day, Year)

7 State

Registra

ASHOKA 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

900 S. CATON AVE, BALTIMORE, MD 21229 INDUKURI

RESIDENT PHYSICIAN

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

24060

MAY 05 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2010

			1 - For State Registrar	State	or Marylar	•	tificate of Deat		, ,	teg. No.	0	14599
	Physicia	an/	1. Decedent's Name (First, Mi						. Date of Dear		Year	3. Time of Death
	Medi	cal	Frederick Wi 4a. Facility Name (if not institu						May 5,	2010		3:20 A M
	Examir	ner		utheran Vi	-		4b. City, Town, or Locat Westmi			4c. County o	of Death I rro 1	1
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Year If Ur	nder 24 Hrs. 8	. Date of Birth	1	9. Birthp	lace (State or Foreign
	Director		215-40-1933	1 🕅 M 2 🗆 F	67	Yrs.	Months Days Hou	urs Min.	(Month, Day, ct. 26	, 1942	Mar	yland
	ind show at	٦	Usual Residence of Decedent 10a. State 10b. Cou	nty	10c. Cit	ty, Town or Lo	cation				10	Od. Inside City Limits
	//aryla 8a-f s tified	Director	MD Ba	ltimore			Reistersto	wn				1 🗌 Yes 2 🛣 No
	a or 2 be no		10e. Street and Number				10f. Zip Code			10g. Citizen of W		
	h with ns 23 must	Funeral	304 Northwa							United	Stat	es
10	r deal	y Fu	11. Marital Status 1 □ Never Married 2 🔀 I	Armyned F		S. 13. V	Vas Decedent of Hispanic Yes, specify Cuban, Mex	c Origin? (Specify xican, Puerto Ric	/ Yes or No- an, etc.)		- America , White, e	
936	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho , the Medical Examiner must be notified at	Completed by	3 Widowed 4 Divor	If Von C		1	☐ Yes 2 No Spe	ecify:		Specify:	Whi	te
5-0	2 hour	plet		edent's Education ghest grade completed	4)	16a. Decec	ent's Usual Occupation	most of working		16b. Kind of Bus	siness Ind	ustry
121	thin 73	mo	Elementary/Seconday (0-1		1-4 or 5+)	life. Do	O NOT use retired)			то1ооо		ications
d 2	filed within al Hygiene. d other tha	Be	17. Father's Name (First, Midd.	le. Last)		Syst	em Technici		iret Middle A	1e1eco	minum	<u> </u>
lan	l be fil Fental rked tic ev	၉	Frederick W		m, Jr.			Dorothy				
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relation			19b. Mailin	g Address (Street and Nu	ımber or Rural R	oute Number,	City or Town, Sta	ate, Zip C	ode)
	1 and 2 soft Health item 27 other tra		Sandra K. Da	um - Wife		304 N	orthway Cou	rt, Rei	sterst	own, MD		,
Baltimore,	ge 1a nt of H if ite or oth	1	20a: Method of Disposition 1X □ Burial 2 ☐ Cremat	on 3 🗆 Removal fron	20b. F	Place of Disport	sition (Name of attory Creme Clace) on Forest	Date	- 1	20c. Location - 0		
Iţim	it. Pag irtmen irtant ijury	Y	4 Donation 5 Othe		TO C		Name and Address of Fa	5-12-		Owings		
Ba	permit. Page 1 Department of Important: If i any injury or once.		21 Servius Furneral Servius	rcensee	the Mari		. Name and Address of Fa 28 Sulphur					
			23a. Part 1. Enter the disease	, or complications that	caused the deat							Approximate
mining.	Physician/		shock, or heart failure. Li Immediate Cause (Final disease or condition	st only one cause on e	ach line.	1-1-	VIIII	MPH		2	- 13	Interval Between nset and Death
	Medical Examiner		resulting in death)	a. Due to	(or as a consequ	uence of):	DIN S	19/1	0171	/	1	YEHRS
	Examiner	<u>~</u>	Sequentially list conditions,	b. =-		1						
	e e sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to	(or as a consequ	uence of):						
A.	xecutor and al-tran	Еха	that initiated events resulting in death) Last	c. Due to	(or as a consequ	uence of):						
	aath certificate be executed attending physician and for use as the burial-transit	Physician/Medical		d								
8760	tificatu ng ph	Med	IF FEMALE:									
% ×	th cer ttendi or use	ian/	23b. Was decedent pregnant in the past 12 months?	1 🗆 Live		al death 3 🗌	Ectopic pregnancy			23d. Date		•
Box.	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Preq 9 ☐ Unk	gnant at time of one community of the co	death 5∟	Other (specify)			Mon	ın ı	Day Year
P.O.	that the	by Pr	Part II. Other significant cond	litions contributing to	4		,		33e Die	ingto de de dentrit	oute to the	e cause of death?
JS,	uires in sign	ed b	CHEMOTHE	ERAPY	Ind a	iced	FUKOEN	CEPHA	1 - Ye			ably 4 Unknown
Division of Vital Records,	aw req	Completed	ISCHEM	ic CA	EDÏO!	440	DATHY		24a. Was ar autops			sy findings available
Rec	The late has page	Con				/ /			perform		eath?	
ta	cian: sertific ector,	Be	25. Was case referred to medic examiner?	Hospital:				Death (Check on				T.
Ž	Physi this c	2	1 Yes 2 No	28a. Date	Inpatient 2 of injury	ER/Outpatien 28b. Time of	DOA Other: 4 =			nce 6 Other		
o u	nding th. : After s fune	cate	1 Natural 5 Per		nth, Day, Year)	injury	work? M 1 Ves 2		. Describe no	w injury occurred	1	
isio	Atter er dea ector by the	Certificate:	3 🔲 Suicide 6 🗌 Cou	old not be 28e. Place	of Injury - At ho					eet and Number	or Rural F	Route Number,
<u>S</u>	tal or irs afte al Dir led in			build	ing, etc. (Specify				City or Town	State)		
	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completed filled in by the funeral director, page 2 should be detached for use	Medical	(Check 2 <u></u> Medica	al Examiner: On the ba	sis of examinatior	n and/or investi	ccured at the time, date a gation, in my opinion, deat	th occurred at the	time, date and	d place, and due t	to the caus	se(s) and manner stated
	o the ithin (o the omple	ž	only one) 3 Certify 29b. Signature and title of certi	ing Nurse Practioner:	To the best of my	knowledge, d	eath occurred at the time, of 29c. License number	date and place, a	nd due to the	cause(s) and man	ner as stat	ted.
	F ≯ F ō		Banin	TO T	0		Hans	EEGI	_ '	5 / M	12-	ny, 10a1)
			30. Name and address of person	on who completed cau	se of death (Item	23a) (Type, Pi	int) Kinx	35 D	12/01	<u> </u>	XE	70
	wx'		KEVIN E	REUSTE	72.D.2),	TANEY	TOWK	2 M	d. 2	178	37
	Stat		31. Date filed (Month, Day, Year	1 2010	legistrar's Signat	ture	28		,		-	
	Registra	al .	MAIL	L ZUIU K	wer ,	7. 190	No.					

0-03515			pe or Print in							_	
homas Dobins	ki	1- For State Registrar	tate of Maryla		rtment o tificate o		nd Ment		R	20 leg. No.	10 1460
Physici ledical Exam		1. Decedent's Name (First, Mid- Thomas		ki					Date of Dea Month May 7, 20	Day Year	3. Time of Death 1144 hrs
		4a. Facility Name (if not instituti University Hospital	on, give street and nur	mber)		4b. City, Town, Baltimore	or Location of		, , , , , , , , , , , , , , , , , , ,	4c. County of	f Death
Funeral Director		5. Social Security Number 216–31–9436	6. Sex	7. Age (In yrs. Ia		If Under 1 Ye Months Da	ear If Under	r 24Hrs. Min.		rth(MM/DD/YYYY) 8, 1991	Birthplace (State or Foreign MD Country)
		Usual Residence of Decedent	IAM Z		Yr	s.					Country
Maryland 28a-f show any d at once,	or	10a. State 10b. County		10c. City,	Town or Loca		ltimor	re			10d. Inside City Limits 1 X Yes 2 No
the Mary ta or 28a-	Director	10e. Street and Number 5700 Radec	ke Avenue			10f. Zip Code 2	1206		1	0g. Citizen of Wha	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiens and the Health and Mental Hygiens and unit. If them 27 is marked other than "natural", or items 23a or 28a-f sho mrist. If item 27 is marked other than "natural", or items 23a or 28a-f sho not the traumatic event, the Medical Examiner must be notified at once.	y Funeral		larried 12. Was Dece Armed Fo 1 Yes vorced If Yes, Give Year	2 🔀 No		as Decedent of F Yes, specify Cub	an, Mexican, I			14. Race - White,	American Indian, Black, etc. White
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygens (ant. If iten 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	Completed by	15. Decedent's Education (Spe Elementary/Secondary (0-12) 12			during r	nt's Usual Occup nost of working li les Mana	fe. DO NOT u			16b. Kind of Bus	•
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	Be Con	17. Father's Name (First, Middle Thomas Dobi	, Last) nski	_		-		s Name (F endol		Maiden Surname) argaret	
MD 2121; d 2 should be fil lth and Mental I n 27 is marked umatic event,	2	19a. Informant's Name/Relation: Thomas C. Dob		ther	19b. Mailir 400	g Address (Stre Raritan	et and Numb	simp	al Route Nun	nber, City or Town, le, SC 2	, State, Zip Code) 9681
Baltimore, MC permit. Pages 1 and 2 si Department of Health an Important: If item 27 injury or other traums		20a. Method of Disposition 1 Burial 2 Crematio 4 Donation 5 Other S	_	m State CI	rematory or o	sition (Name of c ther place) DURNEY C		5/8/	^{Date} 2010	20c. Location - 0 Woodbi	ne, MD
Balti permit. Departri Imports		21. Signature of Fun ral Service	Licen ee Dorot.	alquo		Name and Addre Mary PO BO	X 1413	3. Ba	ltimor	~.MD 212	03
Physician /Medical		23a. Part I. Enter the disease, of failure. List only one cause	on each line.			the mode of dying	g, such as car	rdiac or re	espiratory arre	est, shock, or hear	t Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Contact Gur Due to (or as a								
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a	consequence of)							
ed nsit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of)							
e executed cian and rrial - trans	g	UNPENDED	d AMENDED								
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Un	ne 1 Live bir	nt at time of dea	2 Fe	etal death 3 ther (Specify)	Ectopic p	pregnancy	/	23d. Date of de Month	elivery Day Year
ires that the signed by the be detached	þ	Part II. Other significant condit	ions contributing to	death but not res	sulting in the	underlying cause	given in Part	t I.		bacco use contribu	ute to the cause of death?
of Vital Records, ng Physician: The law require Nfer this certificate has been si meral director, page 2 should b	Completed								24a. Was a autops perfor	sy prio med? dea	ere autopsy findings available or to completion of cause of ath? Yes 2 No
tal Rectian: The	Be	25. Was case referred to medica examiner?					e of Death (C		one)		
of Vi ing Physi After this funeral dir	은	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 🗹 In	f Injury 2	R/Outpatient 28b. Time of		Other ₄ 1			Residence 6 now injury occurred	
Division tall or Attendin rs after death. The Director: A led in by the fur	Certification:		stigation 28e Place		0255 hrs	1	Yes 2 V N	40	bject shot	v = -	or Rural Route Number, City
Division To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide dete	d not be	Multi-Family	Apt.			570	or Town, St 00 Radecke	tate) Avenue, Baltim	ore, MD
To the Hospital within 24 hours To the Funeral completely filled	Medical	one) 2 Medical Exa	miner:On the basis of and manner sta	examination and	d/or investiga	tion, in my opinio	n, death occu	urred at th	e time, date a	and place, and due	to the cause(s)
	Σ	29b Signature and title of certified	e Shue			29c. Licen	se number M.E.			29d. Date signed May 8, 2010	(Month, Day, Year)
		30. Name and address of person Margarita Korell MD.	who completed cause Assistant Medi	•	•	enn Street, E	Baltimore,	MD 212	201		

			1 - For State Registrar	State of Mary		artmen ertificat			and Me		giene Reg. No.	010	14601
ű.	Physicia /Medic		1. Decedent's Name (First, Middle	DINAR	DI					2. Date of Dea Month	th O2	Year 201	3. Time of Death 0 20:16 PM
	Examin		4a. Facility Name (If not institution, GREATER BALT	MORE MEDI		ER	E	Location of	IM	ORE			MORE
*	Funeral Director		5. Social Security Number n/a Usual Residence of Decedent	6. Sex 1 ☐ M 2 💢 F	n yrs. last birthday Yrs.	Months	Days 7	If Under Hours	Min.	B. Date of Birtl (Month, Day April	26, 2	9. Birth Co Ma	hplace (State or Foreign untry) aryland
	death with the Maryland ims 23a or 28e-f show if must be notified at	ctor	10a. State 10b. County	chess	c. City, Town or t Fishk								10d. Inside City Limits 1 ☐ Yes 2 🎇 No
	with the	Director	10e. Street and Number			10f. Zip		0.1			10g. Citiz	en of What Co	untry?
36	be filed within 72 hours after death with the Marylan hall Hygiene. In the Hygiene of the mark 53a or 28e-1 show a other than "natural", or liams 53a or 28e-1 show avent, the Madreal Examiner must be mailified at	by Funeral	962 Huntington 11. Marital Status 1 X Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces?	r in U.S. 13	. Was Dece If Yes, spe 1 \(\text{Yes} \)			gin? (Spec n, Puerto R	ify Yes or No- ican, etc.)		USA 4. Race - Ame Black, White Specify: W	
21215-0036	within 72 hou ene. then "natura he Mcd cal E	Completed	15. Decedent (Specify only highes Elementary/Secondary (0·12) n/a	s Education	(Giv life.	edent's Usus e kind of wa DO NOT u	rk done d	during mos	t of working	g	16b. Kin	d of Business/	
	I Hygie other	0	17. Father's Name (First, Middle, I	· · · · · · · · · · · · · · · · · · ·		11/а		18. Mothe	er's Name	(First, Middle,	Maiden S		
Maryland	should be nd Mental marked c	To B	Peter	Dinardi				Ma		An	· ·		browski
Mar	d 2 sh th and th and traum		19a. Informant's Name/Relationsh Peter Dinardi/			-				Route Numbe Fishki		Town, State, 2 NY 125	
Baltimore,	nit. Pages 1 and 2 should artment of Health and Mer ortent: If item 27 is marke injury or other traumatic 8.		20a. Method of Disposition 1 XBurial 2 Cremation 4 Donation 5 Other (Sp	3 □Removal from State	20b. Place of Disposer cometery, cr	oosition (Nar ematory or o	ne of other plac	e)	Da	ite	20c. Loc	ation - City or	
Balti	permit. Page Department o Importent: If any injury or		Dujeu,	icens Class		22. Name ar	nd Addres	s of Facilit	ty				y Incines
Physician /Medical Examiner 23a. Part1. Enter eld sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or feart filture. List only one cause on each line. PREMATURIT Due to (or as a consequence of): MASSIVE INTRAVASCULAR Em											rest,		Approximate Interval Between Onset and Death 7 days
760, 3	ite be executed ysician and ne burial-transit	cal Examine	if any, leading to immediate cause. Enter Underlying Cause, Undead or injury that initiated events resulting in death) Last	. PNEum	Due to (or as a consequence of): BRAIN AIR EMBOLUS								7 days 7 days
P.O. Box 687	Attending Physicien: The law requires that the death certificate cardadh. scrobath. scrobath. by the this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 WNo 9 □ Unknown	23c. If yes, outcome of positive birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	□Ectopic pr					23	3d. Date of del	iv ery Day Year
	w requires that been signed b should be deta	þ	Part II. Other significant condition PN Eumo PE	ns contributing to death but n		underlying o	ause give	en in Part I.		23e. Did to	_		the cause of death?
Vital Records,	ne law req has beer ge 2 shou	Completed	BRADYCAK	LOIA						24a. Was			stopsy findings available completion of cause of
<u>=</u>	ysicien: The Is certificate ha		SHOCK							perfor	rmed? 2 ☑ No	death?	2 No
	/sicier s certif directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2 ER/Outpati	ent 3 DC	Oth	ar:		(Check only o		Other (Spec	cifv)
Division of	inding Physiath. ir: After this te funeral di	atlon; T	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investig	28a. Date of Injury (Month, Day Ye	28b. Time	of 2	28c. Injun Worl	at at	21	Bd. Describe h			,
Divis	tel or Atters after de el Directo	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	building, etc. (5	Specify)					City or Tou	vn, State)		ural Route Number,
	To the Hospitel or Attending Ph within 24 hours atter death. To the Funerel Director: After th completely filled in by the funeral	ledical	(Check only 2 Madical E	g Physician: To the best of m examiner: On the basis of ex- and manner stated	amination and/or	investigation	i, in my o	pinion, dea	nd place, as ath occurre	d at the time,	date and p	place, and due	to the cause(s)
	with To	Σ		u-Ndubuis	-) (54	130			signed (Monti	n, Day, Year) 2,2010
	\		30. Name and address of person of DLACH MEZU	-NDUBUISI,	MD;6	e, Print)	1. Ct	HARL	23	ST; BA	YLTH	MORE	mD21201
200	Sta Registr	ar 🤄	31. Date filed (Month, Day, Year)	Server A.		9							

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			1 - State of Mar	-	artment of H <i>tificate of D</i>			jiene Reg. No.2 (1 1 1	11.602
		,	Hegistrar Decedent's Name (First, Middle, Last)		anouto 1.	, oatr.	2. Date of Deat	th	3. Time of Death
	Physicia Medic		Catherine Frances Dunkes				May	7 2010	8:45 P M
	Examin		4a. Facility Name (if not institution, give street and number)			Location of Death		4c. County of Dear	
-	Funeral		53 Tradewind Circle 5. Social Security Number 6. Sex , 7. Age (f	In yrs. last birthday)	Cockeysv If Under 1 Year	/1116 If Under 24 Hrs.	8. Date of Birth	Baltimor	tholage (State or Foreign
	Director		219-10-5796 1 M 2 M F 85		Months Days	Hours Min.	Jan. 24	1, 1925 Co	Maryland_
	show d at		Usual Residence of Decedent 10a. State 10b. County 1	I0c. City, Town or Loc	ection				
	a-f sh fied a	cto							10d. Inside City Limits 1 ☐ Yes 2 🌠 No
	or 28	Dir	10e. Street and Number	Cockeysvi	10f. Zip Code			10g. Citizen of What Co	I
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	Funeral Director	53 Tradewind Circle		21030			JSA	Jane y
	items ner m	Fun	11. Marital Status 12. Was Decedent Eve Armed Forces?			spanic Origin? (Spe n, Mexican, Puerto I		14. Race - Ame	
20	after or samir	ğ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No	_	Yes 2 X No		Hours every	Black, White	
⋛	ours atura	Completed	3 Widowed 4 WDivorced Year or Dates.		fent's Usual Occupa			16b. Kind of Business	vhite
9500-612	a 72 h an "n Medi	Idmi	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give k		luring most of worki	ng	100. KING OF BUSINESS	Industry
717	withir giene ner th t, the		6	Babys	itter		<u></u>	Child Care	
na Ind	be filed ental Hy rked oth ic event	To Be	17. Father's Name (First, Middle, Last)			18. Mother's Name		flaiden Surname)	
Maryland	should be fil and Mental is marked raumatic ev	-	Austin C. Downes 19a. Informant's Name/Relationship (Type, Print)			Theresa		T 01-1- 7:	
	12 sho lith and 27 is 1		Francis Dunkes / son	City or Town, State, Zi					
ē,	of Health of Health fitem 27 r other tra		20a. Method of Disposition	20b. Place of Dispos	sition (Name of			20c. Location - City or	
Baltimore,	permit. Page 1 Department of Important: If it any Injury or o once.		1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, crem Moreland I	natory or other place Memorial	· •	/2010	Parkville,	МП
<u> </u>	permit. Departn Importa any Inju		21. Signature of Funeral Service Licensee		. Name and Addres		<u> </u>		York Road
מ	g ⊆ F F S		Willer allow			<u>Funeral</u>			on, MD 21204
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	5-90			r respiratory arre	st,	Approximate Interval Between
~ P	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	ly Arti	Evy de	sease			Onset and Death
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2	icate be executed g physician and s the burial-transit	edical	d. Hypert	tension					11 aug
20	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	/Me	IF FEMALE: 23c. If yes, outcome of	pregnancy				22d Date of de	
рох	atten atten I for u	sician/M	in the past 12 months? 1 Uive Birth 2 1 Ves 2 2 No 4 Pregnant at time	Fetal death 3 🔲	Ectopic pregnancy Other (specify)	у		23d. Date of de Month	Day Year
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ב ב	: The icate h							med? death? 2 No 1 Yes	s 2 100
NIT .	sician, certifi irector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient	- C-5/0.4-4-4-	Othe	ace of Death (Check			
0 10	y Physer this er this eral d	e: To	27. Manner of Death 28a. Date of injury	28b. Time of	28c. Injury	4 L Nursing Ho		ence 6 Other (Spec w injury occurred	;ify)
ב ו	ath. r: Afte	ficat	1 Natural 5 ☐ Pending (Month, Day, Y 2 ☐ Accident Investigation	/ear) injury		? Yes 2 \square No			
VISION	r Atte ter de irecto	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc. (5	- At home, farm, stree Specify)	et, factory, office	1	28f. Location (Str City or Town	reet and Number or Ru n, State)	ıral Route Number,
<u>בֿ</u>	vitar o urs af yral Di					1			10
	Hosp 24 ho Fune eted f	Medical	29a. Certifier 1 Certifying Physician: To the best of my (Check 2 Medical Examiner: On the basis of exam	mination and/or investi	igation, in my opinior	n, death occurred at	the time, date and	d place, and due to the	cause(s) and manner stated.
4	fo the vithin fo the compl	Σ	only one) 3 La Certifying Nurse Practioner: To the best 29b. Signature and title of certifier		29c. License	number	2	9d Date signed (Mont)	
			* Kamul Bangaria,	M.D.	D00	6564:	1	05/10 A ROAD	12010
	1		30. Name and address of person who completed cause of deat		rint) 2	2314 E	. JOPP	A ROAD	PARKVZLLE
	4		KAMAL C. IBANGO 31. Date filed (Month, Day, Year) 32. Risistra's	RIA, N	1 · D ·			MD-	21234
	Stat Registra		31. Date filed (Month, Day, Year) 32. By distrar's	Signature	2				

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
AMEND ITEM#5perFH, G904,6/4/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Eshmont 2010 Edward Α. Mav 6:30a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4053 Pebble Branch Road Ellicott City Howard 200 al Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Months Hours ^{Country)} Pennsylvania 220-42-5034 Director 56 Usual Residence of Decedent 28a-f show 10a. State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits Maryland 1 🗌 Yes 2 🔀 No Howard Ellicott City 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 4053 Pebble Branch Road 21042 United States items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin Black, White, etc. Completed by 1 Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **5+** Law Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Alice M. Bulla Edward S. Eshmont 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cathy Eshmont/Wife 4053 Pebble Branch Road. Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 5/11/2010 Baltimore, Maryland Metro Crematory Inc. 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facilitremation Society of Maryland, Inc. 299 Frederick Road, Balti<u>more, Maryland 21228</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Set and D. ath Ph sician/ Due to (or s a consuence of): disease or condition resulting in death) Medical Examiner hemia Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No jo Day 4 Pregnant at time of death 9 Unknown 5 Other (specify) Month Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown Hypertensson 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? sompleted filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 🗓 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 🛚 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 1 24 hours after deat e Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔯 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [within 2 only one) 29b. Signature and title of sertifier 29d. Date signed (Month, Day, Year) D0065430 05-10-2010 luliana 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hall Drive State

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5, per FH G903 5/20/10 TT State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Year Month Day **Physician** Elliott AM John Hubert 2010 0100 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Roredale Balnmore tranklin Savare Hospital 9. Birthplace (State or F Country) N.C. If Under 1 Year | If Under 24 Hrs. Social Security Number 246 – 66 – 7712 Date of Birth (Month, Day, Year) 6-19-1945 7. Age (In yrs. last birthday) (State or Foreign Funeral Hours Min. Days **№** M 2 🗆 F Months 64 Director Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Director 1 ☐ Yes 2 X No Middle River MD Balto Co 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 21220 USA 9 Benoni Circle Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. filed within 72 hours after 1 Never Married 2 Married 1 □ Yes 2 □ Kno Baltimore, Maryland 21215-0036 Black Specify þ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meritan injury or other traumatic event, the Meritan Truck Driver Dumping 8th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lena Williams John Henry Elliott ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah C. Scott-Friend 9 Benoni Circle Middle River, MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5-15-2010 4 ☐ Donation 5 ☐ Other (Specify) Dunn, N.C. Rest Haven Cem 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ser Mileral Ser East F/H March Balto, MD 21202 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death cosis Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner avalogenic snock Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Chemic Cardiomyopat and the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical as use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy for t in the past 12 months? Month Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐No detached 9 Unknown 9 ☐ Unknown ģ signed I I be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ESP vascular al stast 1 Yes 2 No 3 Probably 4 Unknown peen n roy Illanor 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? has page 2 certificate 2 1 No 1 □ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Minpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 □Yes 2 □ No 2 Accident after death Director: 6 □Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide e Funeral (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2 To the I 29b. Signature and title of centifier 29c. License number 29d. Date signed (Month. Day, Year)

State Registrar

DHMH 17 Rev 1/2001

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Sa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tranklin

32. Registrar's Signature

9600

Year)

Dr. Fawad Tariq

31. Date filed (Month, Day,

RES 0000

Bultmare MD 21237

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2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Barbara Jacquelin		=IIISON Stat I- For State Registrar	te of Marylan		oartment o e <i>rtificate o</i>		id Ment	tal Hyg		eg. No.		460
Physician Medical Examine	1/	 Decedent's Name (First, Middle, L Barbara Jacque) 		ne E11	ison				Date of Dea Month May 5, 20	Day Ye	ar	3. Time of Death 1745 hrs
		4a. Facility Name (if not institution,				4b. City, Town, or	r Location o		viay 5, 20	4c. County	of Death	
Funeral	4	University Hospital 5. Social Security Number 6.	Sex 7.	Age (In vre	. last birthday)	Baltimore	ar If Under	24Hrs 18	Data of Bi	rth (MM/DD/YYYY	A O Rid	thplace (State or
Funeral Director		215-62-3312	M 2 ∑ F	57	Y	Months Day		_	10/10		Foreig	
y n s	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Loca	ition						10d. Inside City Limits
and show	۱.	MD Montgon	nery	Ве	thesda							1 Yes 2 No
e Maryl or 28a-1 ied at 6	Ulrector	10e. Street and Number				10f. Zip Code			1	0g. Citizen of W		•
with the		10012 Mayfield I	12. Was Deced	ent Ever in	U.S. 13, W	20817 as Decedent of Hi	spanic Origi	in? (Specit	fy Yes or No	United		tes can Indian, Black,
	/ runerar	1 Never Married 2 Marri 3 Widowed 4 Divorce	1 Yes	es? 2 No	lf.	Yes, specify Cubar	n, Mexican,	Puerto Ric	an, etc.)	White	e, etc. Whit	
hours a	8 8	15. Decedent's Education (Specify			16a. Decede	nt's Usual Occupa	tion (Give k			16b. Kind of Bu	siness/Ir	ndustry
36 thin 72 than "	Completed	Elementary/Secondary (0-12)	College (1-4 5+	or 5+)	1	strator		,		Non-Pr	ofi	t
5-00 iled wit Hygien I other		17. Father's Name (First, Middle, La	st)		1					Maiden Surname		
2121 rould be fi d Mental I s marked tic event,		John Detmer 19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Stree			aesch	nber City or Tow	n State	Zip Code)
MD d 2 sho lth and n 27 is aumati	1	Kurt A. Ellison-			10012	Mayfiel	d Dr.			MD 20817	7	
Ore, ges 1 an of Hea If iter	1	20a. Method of Disposition 1 Burial 2 Cremation	Removal from	State	crematory or o		- 1		ate	20c. Location -	•	
nit. Pagartment sortant	ŀ	4 Donation 5 Other Speci				e Cremto		05/0	8/201	Beltsv		e, MD Gist Ave
	1	made		ľ		pp Funer				Ser. Si	llvei	Spring MI
Physician /Medil Examiner	l	23a. Part I. Enter the disease, or cor failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)	each line. Prim a. COmplica Due to (or as a co	ary h ted b	emorrha y multi	ge of the	e righ	nt tha	alamus	est, shock, or hea	art	Approximate Interval Between Onset and Death
ī	5	Sequentially list conditions,	b. Dus to for as a co.	isequei ice	of).							
50, te be executed sysician and burial - transit		cause. Enter Underlying Cause	c. Due to (or as a co									
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certifica certifica anding ph	2	F FEMALE: 3b. Was decedent pregnant in the past 12 months?	1 Live birth	office of pro-	2 F	etal death 3 (pregnancy		23d. Date of Month	delivery Da	ay Y ear
the death by the atte		1 Yes 2 No 9 V Unknow	3 Unknown				iven in Part	1	23e Did to	hacco use contri	bute to t	he cause of death?
P.O. res that the signed by the detached by P.O.	3	10				andony mg codoo g	, voir in t and					ably 4 🗸 Unknown
of Vital Records, ng Physician: The law require. ther this certificate has been signeral director, page 2 should be n: To Be Completed	ואומות						_	_ i	24a. Was a autop	sy p		opsy findings available empletion of cause of
Ital Recision: The certificate rector, page		25. Was case referred to medical	r			26 Place	of Death (C	heck only	1 Yes		✓ Yes	2 No
F Vital Physician r this certi ral director	L	examiner?	Hospital: 1 🗸 Inpa	tient 2	ER/Outpatien		Other ₄		,	Residence 6	Other:	
n of 'oding Ph. h.: After t e funeral		7. Manner of Death 1 Natural	28a. Date of I	/,Year)	28b. Time of		ryatWork? ′es 2∭ N	su Su	Describe h	driver	öf v	ehicle
Division ospital or Attending tours after death. neral Director: After filled in by the functor. Certification:		2 X Accident Investige 3 Suicide 6 Could no	Fd 5/1, 28e. Place of		Fd 10:4	et, factory, office b		S t :	Location (S	railer	er or Rura	al Route Number, City
Divi Divi spital or hours afte neral Dir / filled in		4 Homicide determin	ed (Specify)	•	ng lot					tateOld Ge Ey Rd, B		
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	180100	one) 2 Medical Examine	cian: To the best of er:On the basis of ea and manner state	amination a								
Š		9b. Signature and title of certifier	11 -		\	29c. License		OCME		29d. Date signe May 6, 201		h, Day, Year)
	3	0. Name and address of person who		death (Iten	n 23a)			-				<u></u>
		Theodore M. King, Jr., M				111 Penn Str	eet, Balti	more, M	ID 21201			
State	9 ^{[3}	1. Date filed (Month, Day, Year)	32. Regist	rar's Signat	ure	A						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GYLT Month 8.65 PM RUGER HOMAS 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** COUNTY GON AVA HUWARIN HOWARD HOGAT STUMB 5. Social Security Numbe If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 Days Aug. 18 ^Y1926 New York 487-36-3765 83 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director 1 Yes 2X No Marvland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10617 Green Mountain Circle United States 21044 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give Year or Dates. WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2X No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Commercial Construction Electrical Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Η. Fort Eve1vn Burke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter L. Fort/ Son Harbor Lane, Columbia, Maryland 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 5/10/2010 Baltimore, Maryland 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIL SHOUL disease or condition resulting in death) 30445 Due to (or as a consequence of) 1 WEEK DIFFIGLE CLUSTRIDIUM COSU TIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of)

Physician/ Medical Examiner

and tran

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

should be file and Mental F

permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau

Exam Physician/Medical

IF FEMALE:

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Completed

Be

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Certificate:

Medical

d.			
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Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregna 5 ☐ Other (specify)

Ectopic pregnancy

26. Place of Death (Check only one)

23d. Date of delivery Month Day

Year 23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PREUMONIA

23b. Was decedent pregnant

Unknown

in the past 12 months?
1 ☐ Yes 2 ☐ No

URINARY TRACT INFECTION

-	24a. Was an
-	autopsy
	performed?
- 1	1 Yes 2 N

1 Tes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available prior to completion of cause of

_		-
5.	. Was case referred to medical	
	examiner?	

28a. Date of injury (Month, Day, Year) 5 Pending

Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28b. Time of 28c. Injury at work?

No	death?	2 100	

Natural ☐ Accident ☐ Suicide Investigation 6 Could not be

27. Manner of Death

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

	28d. Describe now injury occurred
No	
	28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

29b. Signature and title of certifier

036974

29d, Date signed (Month, Day, Year) 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10710 CHARTER DR

MELMAYM. O m

32. Registrar's Signature

COLUMBIA MO

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G904,6/1/2010, WS
State of Maryland / Department of Health and Mental Hygiene | | | State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Month John Felger 20T0 12:54P ™ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 20 Hanford Drive Harmans Anne Arundel 8. Date of Birth Sept. 20,1955 Birthplace (State or Foreign Country) 6. Sex 1 ☑ M 2 ☐ F . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Min. Months Hours 54 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "---- any injury or other than". 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Funeral Director 1 ☐ Yes 2 No MD Anne Arundel Harmans 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20 Hanford Drive 21077 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1X Never Married 2 Married Yes 2 X No 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Maintenance Westinghouse Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Louis Felger Margaret L. Keefer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Donna Cecil/Sister 111 Glenmount Avenue Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 12 2010 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem.Park Elkridge, MD 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a coi Examiner Sequentially list conditions, if any, leading to immediate name. Enforcing the sequence of the Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to dead but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy perform 2 🗌 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: ၉ 1 Tes 2/ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After th completed filled in by the funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🗹 Certifying Physícian: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 7/2009

Dr Miguel A. Heredia M.D.

wno completed cause of death (Item 23a) (Type, Print)

413 Commonwealth Avenue Baltimore, MD 21228

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Philip Reece Forrester May 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 320 Quaker Ridge Road Timonium Baltimore Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Ye Dec 24 9. Birthplace (State or Foreign **Funeral** 1 ★ M 2 □ F Director 178-32-0406 68 Dec. Usual Residence of Decedent oortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD Baltimore 1 Yes 2 X No Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 320 Quaker Ridge Rd. 21093 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces Completed by 1 Never Married 2X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Restauranteur Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ralph E. Forrester, Jr. Mary L. Reece 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Ann Forrester/wife 320 Quaker Ridge Rd., Timonium, MD 21093 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 once. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 5/7/10 Glen Burnie, MD 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Rd., Timonium, MD 21093 Signature of Funeral Service Dic usee Michae 1 Enter the disease, of 23a. Part 1. ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ ancinoma ung disease or condition resulting in death) even mont Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be execute signed by the attending physician and dbe detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Dav Year 1 Yes 2 L 9 Unknown 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by | 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown Completed After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 K Residence 6 Other (Specify) Hospital 2 📈 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending Accident
Suicide Investigation Director; in 24 hous.

the Funeral Dire.

I filled in by th 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Vear **Physician** \mathbf{A}^M 15 2010 8:05 April John B. Ferra /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Woodland Assisted Living Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 🔀 M 2 🗆 F March 7, 1920 Arizona 90 Director 527-16-1050 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Micical Exeminating must be notified at 1 Yes 2 □ No Director Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with t Hygiene. other than "natural", or Items 23a or 3 21220 USA 1320 Windlass Drive 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ∐Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 ☑ No Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) automotive repair person 12 should be filed with and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Vivian Laverne Joseph Ferra ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2
Department of Health &
Important: If item 27 is
any Injury or other trausone. Deer Haven Lane; White Hall, Maryland 21161 Linda Gerard/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronal d Wilde 22 Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 2 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ncham (KUCZON **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 KINo 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 24 No 1 ☐Yes 2 ☐ No certificate Hospital or Attending Physician: 25. Was case referred to medica examiner? 26. Place of Death (Check only one) funeral director, Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Magner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 04-28-2010

State Registrar 31. Date filed (Month, Day, Year) 32. Redistrar's Signati

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DASER M

M 709. EASTERN BLV) 32. Registrar's Signature
Server S. Jack

MD-21221

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Stanley W. Gutowski May Month Day 2010 Year 9 10:05pM Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Port Deposit 410 Linton Run Road Cecil . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 182-16-8420 Months Days Hours March 25 87 Director 1923 Usual Residence of Decedent 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Cecil Port Deposit 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21904 410 Linton Run Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1

Yes 2 □ No Black, White, etc. Completed by 1 Never Married 2 Married be filed within 72 hours after If Yes, Give 1 Yes 2 No Specify: Specify: White 3 XWidowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Electrical Tech Westinghouse 12th Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked မ Stanley Gutowski Agatha Nalies Page 1 and 2 should and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .8 Stanley Gutowski Jr. /son 410 Linton Run Road Port Deposit MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Holly Hill Cemetery 5/15/10 Baltimore MD 4 Donation 5 Other (Specify) . Signature of Funeral Service Licenses 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Origin - unknown ances Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence on) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Son's Home ျပ 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred | X Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation after death Director: / 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29d. Date signed (Month, Day, Year) 10 20. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200500 oria 31. Date filed (Month, Day, Year) 32. Reg State Registrar DHMH 17 Rev 7/2009

5

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Robert Day 2010 L. Goolsby Sr. Mav 1:47a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City Town, or Location of Death 4c. County of Death 1564 Alconbury Road Essex Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month Day, Year) April6,1931 1 **X** M 2 □ F Months Days Hours Min 79 218.24.59 Director MD Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Essex 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21221 1564 Alconbury Road USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 XYes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 ☑ No Specify: Completed 3 Widowed 4X Divorced Specify: White Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) l Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Ship Welder MD Dry Dock 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Samuel Taylor Goolsby Martha Naomi Camden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert L. Goolsby Jr./son 1564 Alconbury Road Balto. MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 5/7/10 Bayview Crematory Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Home of Essex Connelly Funeral 23a. Part 1. Enter the disease, or complications that cause ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 10 SC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Pregnant at time of death signed by the a d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performe Yes 1 🗌 Yes 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home After this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 🗆 No Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check the only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) May 200 3064

State Registrar AGMESH Ja 31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

RIVUMECK

Road

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sabapathi

201-109 Back

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 28 April 2010 8:29 A M Lucille Grimes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1928 10, 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** Days Min 1 □ M 2 🖵 F 81 Pitt County, NC December Director 579-58-2730 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State Director 1xxYes 2 ☐ No District of Columbia Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 3008 30th Street SE 20020 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11 Marital Status Black White etc. ģ 1 Never Married 2 Married 1 Yes If Yes, Give 2**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Black Specify 3 ₺ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker Sixth None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roxanne Stancil Moses Jones other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 6873 Red Maple Ct., Forestville, MD 20747 19a. Informant's Name/Relationship (Type, Print) .. Page 1 and 2 st tment of Health a tant: If item 27 is Lucy G. Horne/Daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of permit. Page 1 Department of Important: If it cemetery, crematory or other place) May 8, 2010 1 X Burial 2 Cremation 3 Removal from State Glenwood Cemetery injury 4 Donation 5 Other (Specify) Washington DC 21. Signal by of Pull Service Licensee Donald R. 22. Name and Address of FacilityRobert G Mason Funeral Home Inc any 1661 Good Hope Rd SE Washington DC 20020 s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Pnter the disease, or compli or heart failure. List only one shock, or heart faile Immediate Cause (Final Sepsis Due To Multidrug Resistent Klebsiella Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner <u>Tuberculosis</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death Yes 2 X No the 9 Unknown g Unknown cate has been signed by page 2 should be detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 K No 1 ☐ Yes 2 ☐ No certificate 26. Place of Death (Check only one) Be 25. Was case referred to medica director examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA မ this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: (Month, Day, Year) 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🟅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination allows investigation, in my opinion, decay as a state of the cause (s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 28 201 D 62 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring MD 20910 Sarah Bromeland M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 Day Physician/ Medical May 5, Joseph Lawrence Geisler, Sr. 8:45pm М 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center for Hospice Care Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Davs 219-30-1684 1 **x**X M 2 □ F 76 Director 29. 1933 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director "natural", or items 23a or 28a-f s dical Examiner must be notified MD n/a Baltimore 1 A Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1130 Sargeant Street 21223 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Ś 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examirans. 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) / Crane Operator Bethleham Steel 6 æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William Leo Geisler Mary Louise Gibson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen Geisler 1130 Sargeant Street Baltimore, Maryland 21223 wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bavview Crematory May 10, 2010 Baltimore, Maryland 21. Signature of Europeal Service Licensee 22. Name and Address of Facility McCully Polyniak Funeral Home P.A. 130 East Fort Avenue Baltimore, Maryland 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ Complications Medical Due to (or as a consequence of): Examiner foil Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Physician/Medical Examiner To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Bnd -Stage liw Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director After the the the the the funeral Director After the the funeral Director After the the funeral Director After the function of the func 7 ... 1 ... 1 ... 1 ... Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2. No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner?
1 2 Yes 2 1 No Other: ဂ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 2 Accident 1 Yes 2 No HII off may 1,2010 morning M couch Investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide home Baltimon 130 Servet Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) R149194 May 6, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles MD anGrah 6701 21204 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Registrar
DHMH 17 Rev 1/2001
OCME 2006

111 Penn Street, Baltimore, MD 21201

Donna M. Vincenti, MD

31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32 8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 2010 18:24 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death MOR Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 □ M 2 🔀 F Min. Days Hours 415-56-2656 73 June 8, 1936 Tennessee Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a, State 10b County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Baltimore City Md. 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1155 Frailey 21205 U.S.A. Way 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Examiner Black, White, etc. 6 þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. "natural", 3 Widowed 4 X Divorced Specify: White Completed Year or Dates Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natuuy or other traumatic event, the Medical ury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) 8 t h College (1-4 or 5+) DAP Products, Production Line Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jesse Hornice Massengill Rosa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steve Oxendine (son) 17411 Wilson Street Dumfries, Va.22026 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Мау₃, Department o Important: If any injury or 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Holly Hill MemGar 2010Middle River, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facilit Kaczorowski Funeral Home, PA <u>Dundalk</u> Avenue Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and eath Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) igned by the attending physician and be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O, Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 9 Unknown Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.9 autopsy 1 ☐ Yes 2 € No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1- Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and time of certifier

Registrar
DHMH 17 Rev 7/2009

State

4940

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

31. Date filed (Month, Day, Year,

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Amend #26, per MD & #30 per DVR 2903 5/11/10 TT
State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MAY 06^{Day} **GOLDBERG** 2010 12:57 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NORTHWEST HOSPITAL BALTIMORE RANDALLSTOWN Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 871671949 217-52-7482 60 Director MD Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City. Town or Location Director 10d. Inside City Limits BALTIMORE REISTERSTOWN 1 Yes 2 X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 312 HIGH KNOB LANE 21136 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc 1 Never Married 2 X Married þ 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: WHITE If Yes, Give Year or Dates. Specify: 3 Widowed 4 Divorced Completed er than "natur , the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) CONSULTANT COMPUTERS t. Page 1 and 2 should be filed with rtment of Health and Mental Hygien rtant: If item 27 is marked other th njury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည BERNARD **GOLDBERG** NANCY TANNENBAUM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SONDRA GOLDBERG/WIFE permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 312 HIGH KNOB LANE, REISTERSTOWN, MD 21136 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 Nurial 2 Cremation 3 Removal from State BETH TFILOH CEMETERY! 5/9/2010 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition 1.5 Medical resulting in death) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Month Year 2 No as been signed by the a 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a, Was an autopsy performed? 1 Yes 2 No prior to completion of cause of death? 1 Yes 2 No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 E No Other: မ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier se number 5/7/10 0080s 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jay S. Margolis, MD 90 Rainters Mill Road Suite 135 Owings Mills, MD 21117 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 56 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Year Lorraine Ε. Harper 12:28a May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Frederick Villa Nursing Center Catonsville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country Maryland **Funeral** 1 □ M 2 🔀 F Months Hours Min Feb. 6, 1933 Director 213-32-4489 77 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If firen 27 is marked other than "natural", or itams many injury or other trainmain. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 ☐ No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Rokeby United States Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black 3 Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Walter Williams Robinson Alice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Harper/ Husband 4213 Rokeby Road, Baltimore, Maryland 21229 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Garrison Forest Cemetery or other place) Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/18/2010 Owings Mills, Maryland 22. Name and Address of Facility MacNabb Funeral Home, P.A. Amanda Heaston 301 Frederick Road, Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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completed f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my knowledge, death onto medical the time, date and place, and due to the cause(s) and manner stated. 29c. License number 017746 29b. Signature and title of certifier as2746 may, 11, 2010 Choice lone Bolt MD 2/221 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
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Due to (or as a consequence of): The sequence of the sequen	•						ase						Death
Figure F			or condition resulting in death)	Due to (or as	a consequence of	of):		-					
Security		٦		b. Due to (or as	a consequence of	of);							
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29b. Signature and title of certifier O.C.M.E. April 30, 2010 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	30x death	ysi	1 Yes 2 No 9 Unk		nown	٥_ ٥	inei (-p)	-					
29b. Signature and title of certifier O.C.M.E. April 30, 2010 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	D. E.		Part II. Other significant conditi	ions contributing	to death but not i	esulting in the	underlying cau	ise given in P	Part I.	23e. Did toba	acco use contrib	oute to the c	ause of death?
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30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	To To Com	Med			stated.		29c. Lic	cense numbe	er		29d. Date signe	ed (Month, I	Day, Year)
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Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			10 May 10	iaml/	UPP of dooth (He-	n 23a\							
monoca anadot, ma	¥ 1	.					Penn Stree	t, Baltimo	re, MD	21201			
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Registrar

Amend #5, per Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2010 Month **Physician** 9:15P ELIZABETH LAMB HAINES May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Presbyterian Home of MD Towson 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. Washington 1 □ M 2 🙀 F Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d Inside City Limits 10a, State 10h County 1 ☐ Yes 2√√No Director Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 USA 2525 Pot Spring Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (A) If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Pages 1 and 2 should be filed withir nent of Health and Mental Hygiene. Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is marked o Robert Mattison Elizabeth Swinnerton 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 Is
any Injury or other trau Charles Gordon Haines 2525 Pot Spring Road Timonium, Maryland 21093 Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 XX cremation 3 ☐ Removal from State Date GreenMount Crematory May 11,2010 | Baltimore, Maryland □ Donation 5 □ Other (Specify) 22. Name and Address of FaMTVTCHELL-WIEDEFELD FUNERAL HOME INC ignature of Funeral 6500 York ROad Baltimore, Maryland 21212 23a. Part 1. Enter the dise e, or comshock, or heart failu List only ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death e. or compl Immediate Cause (Final disease or condition resulting in death) Altheimers **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unerfying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 █ No Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by Divertular hemorrhage 1 ☐ Yes 2. 25 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒No 24a. Was an autopsy 1 ☐ Yes 25 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Attending Physica May 037016 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kenneth M. Green, MD 6701 N. Charles St., Sande 4104, Sa Home, MD 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh g903 5-11-10 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician/ OSOM Nonth raine Medical stitution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore lemoria 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date 8 Bill 5_46 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 💢 F Min. Director Yrs. Country) 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location
Ralfinore ms 23a or 28a-f shor must be notified at 10a. State 10b. County 10d. Inside City Limits Director MD 1 ☐ Yes 2 🔏 No 10f, Zip Code 21206 10e. Street and Nymber 10g. Citizen of What Country? Funeral Moravia usA 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. Black Completed 3 Widowed 4 Divorced Specify: 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) cify only highest grade completed) econday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informart's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number Moravia Husbano Haltimore, Maryland 21206 Baltimore, 20a. Method of Disposition

1 Disposition

1 Disposition 3 Removal from State
4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other pla Date HIMOre. Lion Signature of Funeral Service 22. Name and Address of Facility Balto. 16 21214 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition mo Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to for as a consequence of After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I ☐ Yès 2 ☐ No Yes 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? <u>ء</u> Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of De 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 \square Pending work? 1 ☐ Yes 2 ☐ No Investigation
6 Could not be filled in by the ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier More tho completed cause of death (Item 23a) (Type, Print) 30. Name and address of perso veronce 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Diana L. Howard Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death Examiner 4c. County of Death altimore Good Sameritan Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Min. July 16, Baltimore, Maryland Director 217-50-0387 "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🙀 No Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 2300 Taylor Avenue United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 9 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 → No Specify. 3 🗆 Widowed 4 🙀 Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Owner 11 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. William F. Hildwein Bessie G. Foole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana M. Connelly (Daughter) 20a. Method of Disposition 2300 Taylor Avenue Parkville, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Moreland Memorial Park May 13, 2010 Parkville, Maryland Signature of Funeral Service License 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services-Parkville 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. E er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of realt failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ acidosis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Tension Pneumothora Sequentially list conditions, if any leading to increase in the cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last by Physician/Medical Examiner as the burial-transit signed by the attending physician and Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Month Year Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown plnods peen Diabetes 24b. Were autopsy findings available prior to completion of cause of within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? HTN 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No ျှ 1 🗌 Yes 1 Inpatient 2 FR/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 \square Pending (Month, Day, Year) **■** Matural 1 Yes 2 No Accident Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 | Medical Examiner: On the basis or examination and/or investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D066268 may 12 30. Name and address of person who completed cau-32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 643 Carlton Wayne Hockaday, Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** Good Samaritan Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Hours Min. 08-12-1945 Virginia Director 231-58-6465 64 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Baltimore Maryland N/A 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 4605 Willshire Avenue 21206 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married 21215-0036 1 Yes 2 X No Specify: Black "natural", Completed 3 Widowed 4 Divorced Year or Dates Vietnam permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I once. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) U.S. Dept. of Page 1 and 2 should be filed within ment of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Transportation 12 Foreman Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James Mary Alice Hockaday Towns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4605 Willshire Avenue Baltimore, Maryland 21206 Mrs. Norma J. Hockaday - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 05-14-2010 Baltimore, Maryland 21. Signal of Funeral Service Ligensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck. Inc Baltimore. MD 21214 Approximate Interval Between Approximate Interval Between Approximate Approximate Interval Between Int 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each 5 Immediate Cause (Final 5 car den Physician 10 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any leading to introduct cause. Enter Underlying Examiner Due to jor as a consiguence of Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown for Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) signed by the a d be detached for by the P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 has page 2 certificate 25. Was case referred to medica examiner? Division of Vital funeral director, 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA မ this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After 1 Natural injury work? 5 Pending 24 hours after death. Funeral Director: At 2 Accident
3 Suicide
4 Homicide 2 🗆 No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Ercertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Priystoan: to the best of my inverse, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 only one) 29b. Signature and title of certifie 29c. License number 0 5 9 5 7 U 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year,

exprance C. Bulen Proposition So Ol Loch Reven Bi

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Brenda G. Hewitt Physician/ Month 2010 рм May 3:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Silver Spring 4c. County of Death
Montgomery Examiner Holy Cross Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth
(Month, Day, Year)
Aug. 17, 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 203-40-9213 1 □ M 2 🔀 F Director 61 1948 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Montgomery MD Silver Spring 1 X Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? USA 20906 Funeral 14902 Hatteras Way and 2 should be filed within 72 hours after death w Health and Mental Hygiene. tem 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 XMarried Completed by Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 XNo Specify: 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 NIH Science Writer Be 18. Mother's Name (First, Middle, Maiden Surname, Juanita Morris 17. Father's Name (First, Middle, Last) ဂ Nathaniel Josh Garrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14902 Hatteras Way, Silver Spring, MD 20906 Warren W. Hewitt Jr. / Husband item 2 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If it
any injury or of ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/10/2010 Final Journey Crem. Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO BOX 1413, Baltimore, MD 21. Signature of Funeral Service Licencee Dorota, Marshall Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Advanced Metastatic Pancreatic Cancer Physician/ 6 months Medical resulting in death) Due to (or as a consequence of):
Small Bowe Obstruction **Examiner** 1 month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ for in the past 12 months? Day Month Year 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? Yes 2 2 N death? this certificate 1 🗌 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 ∰Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year)
May 7, 2010 29b. Signature and title of certifie. D 0068681 elhwar 30. Name and address of person who completed cause of death (Item 23a) (Type, Prin Charu Maheshwary, M.D., 1500 Forest Glen Rd., Silver Spring, MD 20910 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Suzanne Knipp Huntley May 2010 :26 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country MD Days Hours Nov. 21 .^{Ye}17⁹30 Director 212-30-6757 79 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Baltimore 1 Tes 2 X No Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12261 Roundwood Rd. #401 21093 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 X Widowed 4 □ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Homemaker</u> Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John C. Knipp Marian Guthrie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzanne Berry/daughter 4905 Bart Allen Lane, Baldwin, MD 21013 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 5/7/10 Glen Burnie, MD 21. Signature of Funeral Service Linsee 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Rd., Timonium, MD 21093 Michael B. Carpenter 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition MONTHS Medical Examiner resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or linjury that initiated events Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 ate has been signed by the page 2 should be detached Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 23e. Did tobacco use contribute to the cause of death? CHRONIC KIONEY DISEASE Completed 1 Yes 2 No 3 Probably 4 Unknown BULLOUS PEMPHIADIO 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy DRENAFU ARTIPLY DISTASE performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? the funeral director. Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ HOSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 XOther (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at ... after death ... ure Funeral Director: After completed filled in by the f---28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 1 🗌 Yes 2 🗌 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 064395 Θ, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

mAN, MO

6701 N CHARLES STI SUITE 4105 BALTIMORE, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 4 2010 11:00 P M Margery Hughes May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Montgomery Wilson Healthcare Center Gaithersburg If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 🖾 F Nov 4, 1914 Washington, DC Director 95 214-48-7897 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene.

m 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Marchal Examiner must be notified at 1 ☐ Yes 2 No Gaithersburg Director MD Mongtomery 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20877 403 Russell Avenue #508 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: white 1 □Yes 2 ☑ No Specify. à 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) music teacher education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur Hand League Harriet Ellen Walsmley ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health at
Important: If item 27 is
any injury or other trau Margery Adams/daughter #3 Palisades Blvd; Longview, Texas 75605 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☑ Other (Specify) 22. Name and Address of Facility
State Anatomy Board; 655 W. Baltimore Street 21. Signature of Funeral Service · Wade, + Baltimore, Maryland 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Final disease or condition resulting in death) Gemen **Physician** vear /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the campaign Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and Due to (or as a consequence of): physician a s the burial-1 Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) i signed by the aid be detached for P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. ð disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has r certificate 2 ⊡ No 1 □ Yes 24 hours after death.
Funeral Director: After this certificetely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Man of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division Hospital or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. within 2 29b. Signature and title a certifier 29c. License number 29d, Date signed (Month, Day, Year)

Registra

DHMH 17 Rev 1/2001

State

30. Name and address of persor

31. Date filed (Month, Day, Year)

teven

1 olingh

Russell

who completed cause of death (Item 23a) (Type, Priv

MO

32. Pegistrar's Signature

	1 - For State of Maryland / Department	rtment of Health and Me tificate of Death	ental Hygiene Reg. No. 2010 14627								
Physician /Medical	1. Decedent's Name (First, Middle, Last) Harriett Eliza	abeth Ijames	2. Date of Death Month Day Year 4 26 2010 10:00 PM								
Examiner Funeral Director	4a. Facility Name (If not institution, give street and number) Manor Care 5. Social Security Number 215-22-2126 6. Sex 1 M 2 ▼ F	4b. City, Town, or Location of Death Rosedale If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min. 8	4c. County of Death Balto B. Date of Birth (Month, Day, Year) 9-30-1925 9. Birthplace (State or Foreign Country) VA								
Hygiene. other than "natural", or items 23a or 28a-f show ent, the McJical Examiner must be notified at e. Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Low MD Balto Rosedale	9	10d. Inside City Limits 1⊡Yes 2⊠No								
h with tr	10e. Street and Number 6600 Ridge Road	10f. Zip Code 21237	10g. Citizen of What Country? USA								
al", or items 232 Examiner must by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1	Was Decedent of Hispanic Origin? (SpecifYes, specify Cuban, Mexican, Puerto Ri ☐ Yes 2 ☑ No Specify:	ify Yes or Nocan, etc.) 14. Race - American Indian, Black, White, etc. Specify: Black								
ed other than "natural", or items 23a or 28a-f show event, the Medical Examination that the notified at Be Completed by Funeral Director		dent's Usual Occupation kind of work done during most of working OO NOT use retired) Child Care	16b. Kind of Business/Industry City of Baltimore								
atic event, To Be C	17. Father's Name (First, Middle, Last) Lazaurs Epps	18. Mother's Name (i Helen S	First, Middle, Maiden Surname) tokes								
er traum	19a. Informant's Name/Relationship (Type. Print)daughter 19b. Mailir Ronzella D. Varnado- 6590	-	Route Number, City or Town, State, Zip Code) vd Long Beach, CA 90805								
Important, in item z/ is marked other any injury or other traumatic event, it once. To Be Co	4 Donation 5 Other (Specify) Holly H	· · · · · · · · · · · · · · · · · · ·	te 20c. Location - City or Town, State 2010 Middle River, MD								
any in			rch East F/H enue Balto, MD 21202								
sician edical	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. A SCVD The property of the propert										
g physician and state the burial-transit state burial-transit state stat	Sequentially list conditions, if any leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):										
cian/Me		Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year								
be d	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown								
page 2			24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No								
Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	26. Place of Death (
To the Funeral Director: After this completely filled in by the funeral direction of Medical Certification: To	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) Injury 2 Accident investigation 2 Continue of Death (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 No	e 5 Residence 6 Other (Specify) Bd. Describe how injury occurred								
y filled in by	4 Homicide determined determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	n occurred at the time, date and place, ar									
completely fi	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated. 29b. Signature and title of certifier										
State	30. Name and address of person who completed cause of death (Item 23a) (Type,	whan Wo	ds. food. M1223								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Corrine Jackson 06 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner AGNES BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, July 20, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Hours Year Months Days 1 □ M 2 🗓 F 212-32-9622 73 1936 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10h County 10c. City, Town or Location 10d. Inside City Limits 10a. State ed other than "natural", or items 23a or 28a-f show event, the Diodical Examinant at the Diodical Examinant at 1 X Yes 2 □ No Director MD N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1400 E. Madison Street, Apt. 717 21205 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 💢 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married o. Maryland 21215-0036 1 □Yes 2 No ģ Specify: 3 XWidowed 4 □ Divorced **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Licensed Practical Nurse <u>Hospital / Health Care</u> is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be 1 Health and Mental Alexander Carter Curlene Veney ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once. Robert Smith, son Cedonia Avenue, Apt. A Baltimore, 21206 MD20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 05/10/10 Baltimore, MD 22. Name and Address of Facility MacNabb Funeral Home, P.A. 21. Signature of Funeral Service Licensee George MacNabb 301 Frederick Road Baltimore, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Cli Due to (or as a construence of): disease or condition resulting in death) /Medical Examiner GAP if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed Due to (or as a consequence of) -purialphysician Physician/Medical the attending p for use as t IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 I Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 Probably 4 Denknown 1 🗆 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2□No 24a, Was an Physician: The law has autopsy page ; certificate 2 110 Vital 1 Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO 1 ☐ Yes 1 Thpatient 2 ER/Outpatient 3 DOA Certification: To oţ this After this funeral c 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Division 5 ☐ Pending investigation 1 Natural ithin 24 hours after death.

the Funeral Director: A puppletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical 29a, Certifier (Check only one) and manner stated within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier eh Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 CATON AVE , BALTIMORE MD

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

14 11 2010 Lenius P. 1

32. Registrar's Signature

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside Cify Limits

Approximate Interval Between

Onset and Death

DAYS

4 R2

Year

1 😿 Yes 2 🗆 No

-SSAM

Year 20,0

USA

Month

Day

1 Yes 2 No

am

Black, White, etc.

DHMH 17 Rev 7/2009

State Registrar BHATIA

IANIZ

HOSP OF BALTIMORE, 2401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 18 per fh 9903 5-11-10 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🥎 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 03:50 AM drew Jones May 06 Medical 4a. Facility Name (if not institution, give st Examiner 4c. County of Death Baltimore ltimore City If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign M 2 □ F Months Hours 5 Yrs. Jones Director or 28a-f shov 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If tiem 27 is mared other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Micdical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 🕨 No esvi m more 10e. Street and Numbe 10f. Zip Code Andrew 10g. Citizen of What Country? Funeral 21208 0 ld Cour 0901 45A 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates. 1963 lac 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Self-Cm aloved ટુ 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bonds man Be Known 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maider Hamilton Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number -Hanna mb 21208 Baltimore, Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) Burial 2 Cremation 3 Removal from State 2-2010 4 ☐ Donation 5 ☐ Other (Specify) Signatule of Funeral Service Licencee 22. Name and Address of Facilit MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner eumonia Sequentially list conditions, if any, leading to immediate Examine Cause (Disease or linjury that initiated events resulting in deal) the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans denocarcinoma Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ detached for in the past 12 months? Month Day Year Yes 2 No 1 Lyes Z L 9 Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Was a., autopsy performed? has within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 🗆 No Other: 1 IV Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 W Natural 5 Pending injury 2 🗌 No Accident Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The Certifying Physician: To the best of high knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) doti 32. Registr State Registrar

DHMH 17 Rev 7/2009

/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and P.O. Box 68760, attending physician Įo. the Division of Vital Records, has

certificate Certification: To within 24 hours after deat To the Funeral Director: Medical

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show If a Medical Examiner must be notified at

is marked other than

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra

Physician

traumatic

1 and 2 should be Health and Mental

Director

Funeral

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Completed

Be

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Examine

Physician/Medical

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Completed

Be

4 Homicide

(Check only one)

31. Date filed (Month, Day,

Year

29b. Signature and title of certifier

29a. Certifier

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

Mame and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ORIGINAL

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 1.10FM DAN H. KIRISY 30 DY 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Future Care Homewood Baltimore 8. Date of Birth (Month, Day, Year) Jan. 15, 19 If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 XX M 2 □ F Director 204-40-4197 60 1950 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 □Yes 2 X No Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5424 Whitlock Road 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🕱 No White Specify Specify. δ 3 Widowed 4 Divorced Completed or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumeth. Elementary/Secondary (0-12) College (1-4or 5+) Ship's Officer Dept of Defense 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Kirby June Hockensmith ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 5424 Whitlock Road; Baltimore, MD 21229 Jacquelyn Kirby 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 5/5/2010 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1630 Edmondson Avenue; Catonsville, MD 21228 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiraton **Physician** /Medical Due to (or as consequence of): with Quadraplegic Examiner con varular Sequentially flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Imal burial-tran Due to (or as a consequence of): attending physician Physician/Medical Corney Boles as the asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Honknown 1 Tes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 autopsy performed 2 No 1☐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nersing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | No Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Watural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Hospital or Attending death. 24 hours after death Puneral Director; filled in by the completely

within 2

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

MID

and manner stated.

29c. License number

1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

821 D. EUTAW ST Sonte 308 BALTIMORE MD 21201 MASHMI MD

31. Date filed (Month, Day, Year) 32. Regiorar's Signature Ceneur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 19a, per FH G903, 5/14/10 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>010</u> Month **Physician** 5:55 P ^M Ruth Lily **Kiessling** May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Care Center Oak Crest Parkville 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. Months 1 M 2 XF Days Hours Director <u>220–22–4511</u> 80 8, 1929 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene. Important: If item 221s or 28a-1 show any injury or other traumatic event, the Wedical Exercises could be notified a any injury or other traumatic event, the Wedical Exercises could be notified a gone. Director 1 ☐ Yes 2X No Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 8810 Walther Blvd., Apt. 1501 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: δ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed with and Mental Hygier 7 is marked other the Homemaker <u>Own Home</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Phillips 1 2 2 2 2 2 2 2 2 2 2 Maurice Marv Wert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21234 19a. Informant's Name/Relationship. (Type. Print)
Louis C. Kiessling, Jr. Louis C. Kiessling Husband 8810 Walther Blvd., Apt. 1501 Parkville, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages 1 1 № Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-18-2010 Woodlawn Cemetery Baltimore Maryland 21. Signature of Fune of Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** mula disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of): physician a the burial-68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Year 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 5 Other (specify) signed by the a d be detached for P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy page performed' certificate Vital 1 □Yes or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1□Yes 2☑No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To Division of 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death
1 Natural
2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 29c. License number MD# ROG 7343 5-10-2010 30. Name and address of person who completed se of eath (Item 23a) (Type, Print) M. BRAZIER 8800 WALTHER BIND PARKVITTE, MD. 21234 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #30 per DVR g903 5/11/10 TT State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1715 Morrell Park Avenue n/a Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex . Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 👿 F Months 577-50-1911 Director 72 9/27/1937 South Carolina Usual Residence of Decedent f show 10b. County 10a. State 10c. City, Town or Location be filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD n/a Baltimore 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1715 Morrell Park Avenue 21230 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 - Widowed 4 - Divorced Specify: Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) f Health and Mental Hygiene. Item 27 is marked other than Elementary/Seconday (0-12) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ernest Johnson Estaleen Carterette Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George L. Kramer, Sr. / Husband 1715 Morrell Park Avenue, Baltimore, Md. 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/11/2010 | Brooklyn Park, MD Cedar Hill Cemeterv Signature of Funeral Service License 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, course in June John Cause. Enter Underlying Cause (Disease or injury that is in the course of the course Examine Due to for as a consequence of attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year be detached signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 🗌 No 1 🗌 Yes Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 24 hours after death.

Funeral Director: After this 28a. Date of injury . Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation filled in by the 6 Could not be 28e. Place of Injury - At hor building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) At home, farm, street, factory, office determined Medical 1 Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harold Bob, MD 2835 Smith Ave, Suite 203 Baltimore, Date filed (Month) 32. F gistrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lloyd Asberry Lyons Mav 2010 10:00 А Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Manchester 2820 Michelle Road . Social Security Numbe 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral MXM 2□ F Months Davs Hours Min. OCL. 7, 1944 Country)
Maryland 65 Yrs. Director 5-42-6691 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo Maryland Carrol1 Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America Funeral 2820 Michelle Road 21102 within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1966-Black, White, etc 1 Never Married XX Married \$ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify. "natural", Specify: White Completed 3 Widowed 4 Divorced 1968 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) llth General Contractor Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lawrence Asberry Lyons Printie Bell Ouesenberry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rachel I. Lyons (Wife) 2820 Michelle Road, Manchester, Maryland 21102 20b. Place of Disposition (Name of cemetery, crematory or other place Evergreen Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State May 12 1XXBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) ation 3 🗌 Removal from State 2010 Finksburg, Maryland Signature of Fund 160 ice Licens Eckhardt Funeral Chapel, P.A. 22. Name and Address of Facility au 3296 Charmil Drive, Manchester, Maryland 21102 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death ediate Cause (Final DW Pnysician/ TAS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Secure dially list our little is Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transil that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death the sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 1 Tes 2 12 No ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4
Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 139502MD mi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7, EAST MAIN STREET WESTHINGTER HD

DHMH 17 Rev 7/2009

State

Registrar

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M. ()

82. Registrar's Signature

Hosain

31. Date filed (Month, Day, Year,

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			For State	State of	Marylan		artment tificate			and M	-	_	2111	14636
			Registrar 1. Decedent's Name (First, Middl	e. Last)			incate	OI L			2. Date of De	Reg. No.	Land Sect S. No.	3. Time of Death
	Physici		Barbara	.,			Medu	Nic	1		Month	O6	2010	1:59 AM
47	/Medic Examir		4a. Facility Name (If not institution	n, give street and num	ber)	<u>.</u>	4b. City, To			of Death	1 101 9		. County of Dea	
المرا	Examili	iei	The Johns Hopkins	s Hospital			Baltim	ore	City					
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1		If Under	24 Hrs. Min.	8. Date of Bir	th v. Year)	9. Bi	rthplace (State or Foreign ountry)
	Director		380-20-6407	1 □ M 2 x F	83	Yrs.	WOTHING	Days	Tiodis	IVIIII.	02/02/19	927	Mid	chigan
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	. Town or Lo	cation							10d. Inside City Limits
	Maryla f sho	호	Maryland How		Co	lumbia								1 ☐ Yes 2X No
	r 28a	Director	10e. Street and Number				10f. Zip-C	ode			T	10g. Citi	izen of What C	ountry?
	3a o		8820 Shining Ocean	ns Way Unit	303		210	045					U.S.	Α.
	deatl	Funeral	11. Marital Status		dent Ever in U.S	3. 13.	Vas Deceder	nt of His	spanic Orig	gin? (Spec	cify Yes or No- Rican, etc.)		14. Race - Am	erican Indian,
98	or its		1 Never Married 2 Marr	ied 1 ☐ Yes	2 💢 No		i ⊟ Yes 2 §		Specify:	i, racito ri	irouri, oto.)		Black, Whi Specify:	
21215-0036	hours ural",	d by	3 X Widowed 4 □ Divorced	Year or Dat	tes:		ient's Usual		ation			16h K	and of Busines	White
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D	i Hyg other ent, t	Be C	17. Father's Name (First, Middle,	*					18. Mothe	er's Na me	(First, Middle	, Maiden	n Surname)	
<u>lar</u>	uld be Jenta rked tic ev	To E	Fredrick: Thomas	s Bailey					Na	ada Wi	lamina B	iss		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailir	ng Address (Street a	and Numbe	er or Rurai	l Route Numb	er, City o	or Town, State,	Zip Code)
2	1 and 2 Health em 27 i		Jeffrey Medwid	(Son)			Shining							and 21045
ore	Pages 1 nent of H ant: If iter		20a. Method of Disposition ↑★★ Burial 2 ☐ Cremation	3 Removal from S		lace of Dispo emetery, crem					ate		ocation - City o	r Town, State
Baltimore,	t. Par tmen tant: njury		4 Donation 5 Other (S	- 112	Gle	n Eden (5-13-			nia, MI	1 77 3
Ba	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Funeral Service	acerises .	//	E	lome o	f Ca	atons	ville	Ing Asr	iton-:	Schwad-Wi	tzke Funeral
			23a. Part 1. Enter the disease, or	complications that ca	used the death								sville,	MD 21228 Approximate
Į	Physician		shock, or heart failure. List Immediate Cause (Final	•	4									Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. 50 ps	or as a consequ	ence of):								
	Examiner	L	Sequentially list conditions,	b										
	p #	ine	if any, leading to immediate cause. Enter Underlying	Due to (d	or as a consequ	ence of):								
8.	ecute ind -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to /c	or as a consequ	ence of								
, 60	be executed sician and burial-transit		,,,,											
6876	cate physi s the	edic		d										
9 ×	certifi Iding use a	N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc									23d. Date of de	elivery
Box	de th critificat at ending phy d or use as th	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 🗌 Pregna	rth 2 🗌 Fetal ant at time of de		Ectopic pred Other (spec						Month	Day Year
P.O.	that the dead by the at	Physician/Medical	9 🗌 Unknown	9 🗌 Unkno	wn	_								
S,	The law requires that the death outificate be executed the hese been signed by the allending physician and page 2 should be detached or use as the burial-transit	by F	Part II. Other significant condition	ons contributing to de	ath but not resu	ulting in the u	nderlying ca	iuse giv	en in Part I	ŀ.				to the cause of death?
ord	w requires that been signed I	ted									1 🗆 '	Yes 2	□No 3MP	robably 4 🗆 Unknown
Records,	ne law r has be ige 2 sh	Completed									24a. Was autop		24b. Were a	utopsy findings available completion of cause of
E		ខ									1 Tes	2 No	1 Te	s 2 14No
Ĭ	ysician: Th s certificate director, pa	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:				Othe	r.		(Check only o			
ō	Phys this c	2	27. Manner of Death	28a. Date of		ER/Outpatient 28b. Time of		c. Injury	4 🗆 Nur		e 5 ∐ Resid 8d. Describe f		6 COther (Sperv occurred	ecify)
Division of Vital	Attending Physician: r death. ector: After this certific: by the funeral director,	ertification:	1 Natural 5 ☐ Pendin 2 ☐ Accident investig	9 '	, Day Year)	Injury	М	Work'		No			•	
<u>Vis</u>	Atter er dea ector by th	tifica	3 Suicide 6 Could determ	200, Flace (of injury - At hor g, etc. (Specify)	me, farm, stre	et, factory, o	office		28	8f. Location (Rural Route Number,
Ξ	tal or rs afte al Dir	O								l.				
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b	edical	29a. Certifier 1 Certifyin (check only one) 1 Medical	g Physician: To the be Examiner: On the bar and mann	sis of examinati	rledge, death on and/or inv	occurred at estigation, ir	the tim	e, date and pinion, dea	d place, a th occurre	nd due to the ed at the time,	cause(s) date and) and manner a d place, and di	is stated. Le to the cause(s)
	o the	Mec	29b. Signature and title of certifie	1	er stated.		29c. L	icense	number			29d. Dat	te signed (Mon	th, Day, Year)
	F > F 0		De that	T				RE	5000)		Ma	V 06	2010
	10		30. Name and address of person	who completed cause	e of death (Item	23a) (Type,	Print)						-	L
	10		Hmit Pa	telm.p.	diotroria O'				(600 N	orth Wo	Ife S	t, Baltim	ore, MD, 21287
	Sta Registr	I.G	31. Date filed (Month, Day, Year)	32. Reg	gistrar's Signatu	_	1							
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No._ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2010 4:45 A. Mary Schaffer McManus May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Blakehurst Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 ☐ M 2 🖫 F 1916 94 Feb. 6, Maryland Director 213-01-8103 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Towson Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21204 1055 W. Joppa Road #734 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: \$ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be 1 nent of Health and Mental George Henry Schaffer, Sr. Marv Dinsmore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S 27 permit. Pages 1 and Department of Health Important: If item 27 any injury or other to once. Charles E. McManus, Jr. (husband) 1055 W. Joppa Rd. #734 Towson, Maryland 21204 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Grdns. 5-11-10 Timonium, Maryland 21. Signature of Funeral Service Licensee Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 23a. Part I. Ether the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21212 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Uplan disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of Hospital or Attending Physiclan: The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of): Box 68760. physician Physician/Medical attending pt IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) signed by the s P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1∐Yes 2∭No Medical Certification; To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation To the Hospital or Attenc within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

X CRNP 29a. Certifier completely

Registrar DHMH 17 Rev 1/2001

State

(Check only one)

31. Date filed (Month, Day, Year)

X CRNP 29b. Signature and title of certifier CRNP

Sheron M. Keen Crist

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHARON M. KERN CRWP1055 H. JOPPA ROAD TOWSON, MD 21204

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month V 5 Physician/ Elizabeth Anne Myhill Day 20^{Tear} рм May 8:40 Medical 4b. City, Town, or Location of Death Bethesda 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Suburban Hospital Montgomery Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 463-41-3849 1 M 2 T 49 Months Hours Min. 09/28/1960 Netherlands Director Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Silver Spring 1 🗆 Yes 2 No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10204 Brookmoor Drive 20901 United Kingdom Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Professor Education and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Norton Myhill Margaret Paterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 10204 Brookmoor Drv. Silver Spring, MD 20901 David R. Williams, husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State Chesapeake Crematory 5/8/2010 Beltsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 21. Signature of Funeral Service Licenses MO1539 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Onset and Death Metastatic Breast Cancer Physician/ vears Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or iinjury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? ☐ Live Birth 2 ☐ Fetal deat Year Month Day signed by the a 1 Yes 2 No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ᇫ Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsv performed? death? 2 🗌 No 2 😾 No Yes of Vital 25. Was case referred to medical 쏊 26. Place of Death (Check only one) examiner? ၉ 1 🗌 Yes 2xxNo Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred XX Natural 5 Pending work Division 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Pwithin 2 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) ature and title of certifier 29d, Date signed (Month, Dav. Year) D37236 May 6, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carolyn B. Hendricks, MD; 6410 Rockledge Dr. Ste 506 Bethesda, MD 20817 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 11 2010 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 4639 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Patricia Christina Mitchell 1)=10A WIC Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Ien JEMY Mnnt . Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Min. May 21, Hours **Director** 212-44-4577 63 1946 MD Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2X No MD Anne Arundel Glen Burnie 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4 Baltimore Avenue 21061 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk NSA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Samuel Lilley Anna Ludwig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr Richard Mitchell/Husband 4 Baltimore Avenue Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 2010 Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Brooklyn Park, MD 22. Name and Address of Facility $Singleton\ Funeral\ \&\ Cramation$ Services PA 1 2 ND Ave. SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician disisse hronic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of, Examin Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth Z L 1 each L

Pregnant at time of death 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? been signed by the should be detached Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 2 No 1 Tes ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. Hatural 5 Pending work Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of cert 29d. Date igned (Month, Day, Year) +8006 O 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mi

Registrar DHMH 17 Rev 7/2009

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32. Registrar's Signature

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31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month. Year 2010 MUSEHE 1clean 4:15 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death 5638 Belle Avenue Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 ⋤ F Months Days Hours Min. (Month, Day, Year) Director <u>213-30-3688</u> Mar 26, 1933 No. Carolina Usual Residence of Decedent show 10a. State 10b. County ural", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗡 Yes 2 🗌 No Baltimore Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 5638 Belle Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 ner than "natural", c t, the Medical Exam If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: Specify Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Social Security Administration Clerk permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ida M Miles Moses Miles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5638 Belle Avenue Baltimore, Maryland 21207 Nathaniel Johnson 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 05/07/10 Windsor Mill, Md. 4 Donation 5 Other (Specify) King Memorial Park 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md 2 23a. Part 1 Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ pertension disease or condition yers Medical resulting in death) Due to (or as a consequence) f) Examiner Ulmona N515 Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death ed by the a 9 Unknown Unknown signed to Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy page certificate 2 No 1 🗌 Yes Yes 25. Was case referred to medical funeral director, æ 26. Place of Death (Check only one) Hospital 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29d. Date signed (Month. Day, Year) MO 043152 2010

Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day,

Year)

() (that

Try rd # 131

1591h,

1838

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Miller

10-03555 Gary Manley, Jr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Gary Manley, Jr.		1- For State Registrar	tate of Maryla		artment of ertificate of		d Mental H		Reg. No.	01	1464
Physicia Medical Exami		1. Decedent's Name (First, Mid- Gary J. Manle						2. Date of De Month May 8, 20	Day	Year	3. Time of Death 1330 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death N/B Greensboro Road near Ridgely Road 4c. County of Death Greensboro Caroline								h	
Funeral Director		5. Social Security Number 183–60–2768	6. Sex	7. Age (In yrs. 46	last birthday) Yrs	If Under 1 Year Months Days	If Under 24Hrs Hours Min	-	y31, 196	thplace (State or gn gn puntryPennsyl van	
iow any		Usual Residence of Decedent 10a. State 10b. County Delaware Susse			r, Town or Locati	on		•			10d. Inside City Limits 1 Yes 2 X No
ne Maryland or 28a-f show any <u>fied at once.</u>	Director	10e. Street and Number 9260 Middleford				10f. Zip Code 199	73		10g. Citizen of	What Cou	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral I	11. Marital Status 1 Never Married 2 N 3 Widowed 4 No	Armed For Armed For 1 X Yes Vorced If Yes, Give Yea or Dates:	2 <u>No</u>	If Y	s Decedent of Hisp es, specify Cuban, Yes 2 No	oanic Origin? (S Mexican, Puerto		0- 14. R	/hite, etc.	ican Indian, Black,
0036 within 72 hours giene. Medical Exami	Completed t	15. Decedent's Education (Spe Elementary/Secondary (0-12)	College (1				DO NOT use reti	red)		struct	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	To Be Co	17. Father's Name (First, Middle Gary J. Manley, S	r.		19b. Mailing	Address (Street	8.Mother's Name Kathryn k and Number or F	Kindred	mher City or I	Town State	Zip Code)
mand 2 sho lealth and tem 27 is traumati		19a. Informant's Name/Relation Janice Dunnigan/	Sister	20b.	300 Place of Disposi	9 S. Secono	d Street	Whitehal Date	1 Pennsy	lvania	18052 Town, State
Baltimore, permit. Pages 1 ar Department of Hee important: If itei		1 Surial 2 Crematio 4 Donation 5 Other S 21. Signature of Funeral Service	pecify:		Fairview	er place) Cemetery ame and Address of	5/13		White	hall P	A
Physician		23a. Part I. Enter the disease, or	Blai	aused the death	53	05 Harfo	rd Road	eonard , Baltii	more, N	1D 212	214
/Medical Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	ıries		e mode of dying, s	- as caldiac o	respiratory an	est, shock, or	riedit	Approximate Interval Between Onset and Death
ted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a								
50, te be executed ysician and burial - transit	edical	UNPENDED	d AMENDED								
Sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed retor. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transi	ΣΙ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Un	he 1 Live bi	ant at time of de	2 Feta	al death 3 er (Specify)	Ectopic pregna	ncy	23d. Date Month	of delivery	Day Year
ires that the signed by	اھ	Part II. Other significant condit	ions contributing to	death but not r	esulting in the ur	derlying cause giv	en in Part I.				the cause of death? ably 4 Unknown
Division of Vital Records, tat or Attending Physician: The law requirers after death. at Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed							1 ✓ Yes	osy rmed?		topsy findings available ompletion of cause of s 2 No
Vital F hysician: this certifi	ğ e	25. Was case referred to medica examiner? 1 ✓ Yes 2 No	Hospital: 1 In	patient 2	ER/Outpatient		f Death (Check of ther 4 Nursin		Residence 6	Other	Scene
ivision of or Attending Phafter death. Director: After I in by the funeral	ertification:	27. Manner of Death 1 Natural 5 Pend 2 Accident Invest	stigation	Dav Year) D10	28b. Time of Inj 1225 hrs	1 Ye	s 2 🗸 No	28d. Describe I Motorcycle	driver str	uck fixe	
ː돌 호텔 홈트	ပြု	4 Homicide deter	rmined (Specify)	Local Stree	et	, factory, office buil		or Town, S N/B Greensbo	itate) oro Road nea	ar Ridgely	Road, Greensboro,
To the Hospital within 24 hours To the Funeral completely filled	ledical	(Check only one) 2 Medical Exa 29b.,Signature and title of certific	hysician: To the best miner: On the basis of and manner sta	examination a	nd/or investigation	on, in my opinion, d	leath occurred at	the time, date	and place, and	d due to the	e cause(s)
		Mayonix A	ethill	of death (tra	220)	29c. License r O.C.M.			29d. Date si		th, Day,Year)
		30. Name and address of person Margarita Korell MD.	Assistant Medi	ical Examin	er 111 Pe	nn Street, Balt	timore, MD 2	21201			
Sta Registr	-	31. Date filed (Month, Day, Year)	32. Reg	jistrar's Signatu	ire						

ORIGINAL

Name and Address of the Owner, where	1	6	4	2

	1 - State Registrar		Ce	rtificate of	Death		Reg. No.			
Physician /Medical	Decedent's Name (First, Middle, Li Nancy	Marie		Mazer	•	2. Date of Dea Month	Day	Year	3. Time of Death	
Examiner uneral irector		2 /1050110 Sex 7. Age (1	In yrs. last birthday) Yrs.	4b. City, Town, o	or Location of Death CLC If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 09/20/	4c. Count Bal	y of Death	O1 C lace (State or Foreign try) MD	
wo at	Usual Residence of Decedent 10a. State 10b. County		Oc. City, Town or Lo	cation					0d. Inside City Limits	
Ba-f sh	MD Balti	more E	Baltimore						1 □Yes 2 🙀 No	
any injury or other traumatic event, the Medical Exactives and profited at once. To Be Completed by Funeral Director	10e. Street and Number 104 Whistle Stop			10f. Zip Code 21220			10g. Citizen of U.S.A.	What Count	try?	
by Fund	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of I f Yes, specify Cub I □Yes 2XNo	Hispanic Origin? (Spian, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Ra Bla Specia	ce - America ck, White, e		
it, it a Madical E Completed	15. Decedent's Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give life. I		pation during most of worki d)	ing	16b. Kind of B		lustry	
atic event, III	12 17. Father's Name (First, Middle, Las. Paul	t)	Home Mie	<u>Maker</u> dorfer	18. Mother's Name	e (First, Middle,	Own Ho		Staufer	
٦	19a. Informant's Name/Relationship	(Ťype. Print)			and Number or Rura	al Route Numbe	er, City or Town	, State, Zip		
E	Melvin A. Mazer,				Stop Road,	Baltim				
	1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice	fy)	20b. Place of Dispo cemetery, cren Moreland	Memorial	05/1	2/2010		nore,	Maryland	
once	21. Signature of Funeral Service Lice	T Blan	F F		ess of Facility Leo Ford Road,				4	
for use as the burial-transit a p p p p p p p p p p p p p p p p p p	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	pilications that caused the one cause on each line. a. Due to (or as a co	onsequence of):		ng, such as cardiac o		rest,		Approximate Interval Between Onset and Death	
Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Tho 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Ectopic pregnand Other (specify)	у		1	ite of deliver	ry Day Year	
p S	Part II. Other significant conditions of	, , , , , , , , , , , , , , , , , , , ,							co use contribute to the cause of death? 2 🕱 No 3 □ Probably 4 □ Unknown	
dmo						24a. Was a autop: perfor	sy med?	prior to com death?	osy findings available apletion of cause of	
To Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 🔊 No	Hospital:	2 ER/Outpatien	Oth	26. Place of Death er:	·				
ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Ye	28b. Time of	28c. Injur Wor	y at k? Yes 2 \(\sum \text{No} \)	28d. Describe h)	
Certification:	3 Suicide 6 Could not b	building, etc. (S	Specify)		factory, office 28f. Location (Street and City or Town, State)					
Medical Certification:	one) 2 Medical Exam	nysician: To the best of m niner: On the basis of exa and manner stated.	amination and/or inv	occurred at the tile estigation, in my c	me, date and place, a ppinion, death occurre	and due to the ded at the time, d	cause(s) and mate and place,	anner as sta and due to	ated. the cause(s)	
2	29b. Signature and till of certifier		•	29c. Licens	e number	2	9d. Date signe	d (Month, D	Day, Year)	
State	30. Name and address of person who C. Rangana † h 31. Date filed (Mobilin, Day, Year)	completed cause of death	ishn 9	cool Fra	ntiin Squ	uale Di	ive Ba	ltimo	ore, MD 2123	

DHMH 17 Rev 1/2001

Mazer Naney

Month 05 Physician/ Β. Macijeski Joseph Medical 4a. Facility Name (if not institution, give street and number) 45 CD SAMARITAN4b. City, Town, or Location of Death 4c. County of Death Examiner 5601 LOCH RAVEN BLVD DALTIMORE If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 🗶 M 2 🗆 F 08/17/1928 Director 214-22-7993 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director permit. Page 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heath and Mental Hygiene. Inportant it fleath and Mental Hygiene. Inportant it fleat 27 is marked of other than "natural", or items 23a or 28a-f si any injury or other traumatic event, the Medical Examiner must be notified. MD N/A Baltimore 10e. Street and Number 10f. Zip Code Completed by Funeral 4210 Parkwood Avenue 21206 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status Yes, specify Cuban, Mexican, Puerto Rican, etc." ACITES should be filed within 72 hours after cand Mental Hygiene.
Is marked other than "natural", or 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Elizabeth George Macijeski 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy M. Macijeski 4210 Parkwood Avenue, Baltimore, MD 21206 Baltimore, OSEPH 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillton Svc. 05/11/2010 Corp. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J.Ruck, Inc. 5305 Harford Road,, Baltimore, MD 21214 Conbrosel 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) MYASTHENIA Medical Due to (or as a consequence of): **Examiner** MYCCARDIAL INFARCTION MOIENSTENSION Eaguentielly list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed PERFORATED INTRA-ABDOMINAL VISCU been signed by the attending physician and should be detached for use as the burlal-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ Unknown a I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 🗌 Yes 24 hours after death.

Funeral Director: After this certificate has been 24a. Was an completed filled in by the funeral director, page 2 autopsv 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 2 🛂 No Other: မ 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work?
1 \(\sum \text{ Yes} \quad 2 \sum \text{ No} \) iniury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) Medical

MD

SAPU

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

10d. Inside City Limits 1 X Yes 2 No 10g. Citizen of What Country? 14. Race - American Indian. Black, White, etc. White 16b. Kind of Business Industry Social Security Paduski 20c. Location - City or Town, State <u>Towson. Maryland</u> Approximate Interval Between Onset and Death 23d. Date of delivery Day Month 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Day, Year) 08/2010 5601 LUCH RAVEN BLVD, BALTIMORE

3. Time of Death

9. Birthplace (State or Foreign

2010

04: 40 AM

MD

State Registrar

within 2

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

KARUNAKAR

State
Registrar

1. Decedent's Name (First, Middle, Last)

29c. License number

RES-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

			101	Certificate of Death	Reg. No. 2010 14644					
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)	Mor	of Death 3. Time of Death					
	Medic Examir	cal		4b. City, Town, or Location of Death	Day Year 3:50 PM 4c. County of Death					
أتهمد			5008 Bridgepointe Drive	Chester	Kent					
	Funeral Director		5. Social Security Number 261-29-0616 0. Sex 1 M 2 F 7. Age (In yrs. last birth 55	hday) If Under 1 Year If Under 24 Hrs. 8. Date Months Days Hours Min. (Mo) OCt.	9. Birthplace (State or Foreign Country) 21, 1954 9. Birthplace (State or Foreign Country) D.C.					
	Maryland 28a-f show otified at	Director		10d. Inside City Limits 1 ☐ Yes 2 💆 No						
	with the is 23a or nust be n	Funeral D		10f. Zip Code 21619	10g. Citizen of What Country? USA					
2-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 1 Never Married 2 Married 1 No	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et □ Yes 2 X No Specify:	or No- tc.) 14. Race - American Indian, Black, White, etc. Specify: White					
-6121	thin 72 ho ene. • than "nat he Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Disabled	16b. Kind of Business Industry Never Worked					
ylana z	I be filed w fental Hygi rked other tic event, t	To Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, A						
Mar	id 2 shoulk salth and N n 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Nicole Lyn Moore / Daughter 19b.	Mailing Address (Street and Number or Rural Route I 3173 Kirkmichael Terrace	Number, City or Town, State, Zip Code) e, Bristow, VA 20136					
baitimore,	Page 1 an ment of He ant: If iten ury or oth		1 Device 0 M Commettee 2 Demonstrate Cameter	Disposition (Name of pate y, crematory or other place) 1. Journey Crem. 5/5/2010	20c. Location - City or Town, State Woodbine, MD					
Dail	permit. Departi Import any inj once.		21. Signature of Funeral Service Licensee Dorrota Marshall	22. Name and Address of Facility Maryland Crematic PO Box 1413. Balt	on Services					
Á	nysician/	7/2	23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	ot enter the mode of dying, such as cardiac or respira	tory arrest, Approximate Interval Between Onset and Death					
	Medical Examiner		resulting in death) Due to (or 1 a consequence o	rf):						
	uted Id ansit	amine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	rf):						
2	icate be executed physician and is the burial-transi	ical Ex	resulting in death) Last Due to (or as a consequence of d.	if):						
. DOX 00/00	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	1 Live Birth 2 Fetal death 3 Ectopic pregnancy ass 1 2 months? 4 Pregnant at time of death 5 Other (specify)						
7, L	uires that the signed by the s	ed by PI	Part II. Other significant conditions contributing to death but not resulting in	ions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contrib 1						
necords,	The law rec cate has bee page 2 sho	Complet			a. Was an autopsy performed? death? Yes 2 X No 1 Yes 2 No No					
<u> </u>	sician: certific irector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one	<u> </u>					
5	ing Phy	ate: To	27. Manner of Death 28a. Date of injury 28b. Ti	ime of 28c. Injury at 28d. Des sijury 28d. Des	Residence 6 Other (Specify) cribe how injury occurred					
INISION OF	or Attend after death Director: A in by the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, far building, etc. (Specify)		ation (Street and Number or Rural Route Number, or Town, State)					
2	e Hospital 24 hours a E Funeral I	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or only one) 3 Certifying Nurse Practioner: To the best of my knowle	r investigation, in my opinion, death occurred at the time,	, date and place, and due to the cause(s) and manner stated.					
	To the within To the comp	2	29b. Signature and title of condition	29c. License number 063747	29d. Date signed (Month, Day, Year)					
			30. Name and address of person who completed cause of death (Item 23a) (T		1 1 1 1 1 1					
	Stat	te	31. Date filed (Month, Day, Year) 32 Registrar's Signature	We IM Centerille n	7 21617					
	Registra	ar	MAY 1 1 2010 Store &	parle						
MC	MH 17 Rev 7/20	009	ti t							

DHMH 17 Rev 7/2009

10-03469 Joseph Morlok

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2010 14645 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Time of Death Morlok Month Day Joseph 0058 hrs Medical Examiner May 5, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** 6. Sex 216-98-7451 Months Davs Hours Min Director 1970 39 Aug. 17, MD 1 XM Country) 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 1 X Yes 2 No MD Harford Edgewood 28a-f show notified at once. death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1850 Emily Drive 21040 USA uneral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Never Married 2 Married 2 X No Yes ŭ White Pages 1 and 2 should be filed within 72 hours after nont of Health and Mental Hygiene. 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed Specify the Medical Examiner ≦ or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Baltimore, MD 21215-0036 12 Truck Driver Transportation 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Louis Morlok Rita Hoare event, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis A. Morlok Jr., Father 1862 Emily Drive, Edgewood, MD 21040 of Health 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 5/10/2010 Final Journey Crem. Woodbien, MD Donation 5 Other Specify 22. Name and Address of Facility Maryland Cremation Services PO BOX 1413, Baltimore, MD 21203 21. Signature of Funeral Service LicenseeDerota Marshall Walken 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last ŭ the Hospital or Attending Physician: The law requires that the death certificate be executed and cal UNPENDED attending physician or use as the burial -AMENDED Physician/Med of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month Year for use as Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24a. Was an 24b. Were autopsy findings available autopsy pnor to completion of cause of performed* death? page this certificate ✓ Yes 2 No 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other Nursing Home 5 Residence 6 Other 1 Yes 2 No 28a. Date of Injury (Month, Day Year) May 4, 2010 After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Driver motorcycle auto collision 2054 hrs Division 1 Yes 2 ✓ No 5 Pending 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide 6 Could not be or Town, State)
Route 1 & Route 136, Darlington , Md. determined (Specify) Major Road / Highway 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 Medical (Check only To the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 1308 May 5, 2010 O.C.M.E. alle el 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year, 32 Registrar's Signatur State Registrar

DHMH 17 Rev 1/2001 **OCME 2006**

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Month 20°° 0 11:16 PM McClelland James Lee Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rosedale Baltimore 5822 Shady Spring Loving Living 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth Aug. 28 **Funeral** 9. Birthplace (State or Foreign 81 Days Hours 1 X M 2 🗆 F Year 928 Director 219-22-1291 Marviand Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2**X**☐ No Baltimore Rosedale md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5822 Shady Spring Avenue 21237 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married Yes 2X No If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Freight Worker Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William McClelland Isabelle Ryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert McClelland / Nephew 505 Kenilworth Drive Towson, Maryland 21204 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Hillton Svc. Corp. 5/7/2010 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Lic 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death Coronany CL disease or condition years Medical resulting in death) Due to (or as a conse y ence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death g ☐ Unknown Dav signed by the at the detached for g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed Yes 2 24 hours after death.

Funeral Director: After this certificate 2 🗆 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? ည 1 Yes Other: 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpa 4 Nursing Home 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes Accident 2 🗌 No Investigation Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 To the I only one 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D26534 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year State Registrar

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Ball	permit. Departn Imports any inju		21. Signature of Funeral Service Licensee					^{ss of Facility} Ka dalk Av					Home,PA 4d 21222	4
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24a. Was an autopsy performed? 1 Yes 2 No 3 24a. Was an autopsy performed? 1 Yes 2 No 1								1?	pletion of cause of					
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Division of Vital Records,	Attender deathecter deathecter: /	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - a building, etc. (Sp		rm, street, facto		Yes 2 □ No			Number or	Rural I	Route Number,	
2	pital or burs afte eral Dir filled in	cal Ce	29a. Certifier 1 Certifying Physicia			dooth occured	at the time	data and place o		wn, State)	d manner on	ototo		_
	ine Hos nin 24 h ine Fun pleted	Medical	(Check 2 Medical Examiner only one) 3 Certifying Nurse F	 On the basis of examination 	nation and/o	or investigation,	in my opinic	on, death occurred a	at the time, date	and place,	and due to t	he cau	se(s) and manner state	d.
	vith To 1		29b. Signature and title of certifier				9c. License	number 069223			e signed (Mo			
	10XI		30. Name and address of person who com	pleted cause of death	(Item 23a) (Type Print)					/			_
	Stat	e	Juan A. Marales, 31. Date filed (Month, Day Year)	Ovves, MI 32. Registrar's S	ignature	U 494	o Fasi	levn Aven	ue, Balt	rimor	e, M	<u>D</u>	21224	+
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 2010 7:30 A M May Carol Lynn McConnell /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hospice of Queen Annes Centreville Oueen Annes If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, **Funeral** Hours Days 1 □ M 2 🔯 F 68 Wisconsin Oct 1, Director 391-40-6455 Usual Residence of Decedent death with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f sho event, I'le Madical Examinar must be natified at 1 Tyes 217 No Director Queen Annes Centreville 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21617 Funeral 255 Comet Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Madical Exemina 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 ₹ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: white ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry unk 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) editor 12 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Arthur Roderick Emery Alverne Dorothy Platt ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 375 Hibernia Road; Centreville, Maryland 21617 Beth Covington/friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature 1 speral Service Ronal d 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Wade Director Baltimore, Maryland 21201 Approximate Interval Between Onset and Death **Physician** oav s /Medical Due to (or as a lonsequence of) Examiner Sequentially list conditions, if any locality to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a conse uence of) Hospital or Attending Physician: The law requires that the death certificate be executed thous after death.

Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 2 No 9 Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 NOther (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. within 2 29b. Signature, and title of certifig. 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Mooth, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis

ar's Signature

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aston, MC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Bernard W. Nigrin May 6. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death **Examiner** Balto. 19 Brook Farm Ct. Perry Hall 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours (Month, Day, Year) 1**火** M 2 □ F 216-34-1581 73 Director May 21, 1936 Maryland Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No Perry Hall Md Balto 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21128 USA 19 Brook Farm Ct. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 √ Widowed 4 □ Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Swanson/ Printing 11th Printer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Nigrin Catherine C. Mueller <u>William</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bill Nigrin Son 18 Madeline Avenue Balto. Md. 21206 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 5-10-2010 Balto. Md. Gardens of Faith 22. Name and Address of Facility Schimunek Funeral Home 2705 Belair Rd Nottingham, Md. 21236 21. Signature of Funeral Service License 9705 Belair Rd 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwee shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Oranar disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
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1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 N After this certificate has page 2 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 1 Nursing Home 5 Residence 6 \(\text{Other} \) Other (Specify) ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1. Natural 5 Pending work? 1 🗌 Yes 2 🗀 No Accident Investigation 24 hours after deatle Funeral Director: 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 1 Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) D 55846 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belair Rd 21236 Coodman, MA 602 2500 32. Redistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State	of Marylar	•	irtment of F tificate of			lental Hygi	ené' () g. No.		4650
			1. Decedent's Name (First, Middl	e, Last)						2. Date of Death		Year	3. Time of Death
	Physicia		Arthur N. Neum	an						Month May 6	Day 20	10	3:30 A M
)	/Medic Examin		4a. Facility Name (If not institution	n, give street and n	u <i>mber</i>)		4b. City, Town, o	r Location	n of Death		4c. County	of Death	
	LXdiiiii	Ç.	MD Masonic Hom				Cockeys	vill	.e		Ba1	timo	re
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year		er 24 Hrs.	8. Date of Birth (Month, Day,	Year)	9. Births	place (State or Foreign
	Director		135-14-3887	X□M 2□F	91	Yrs.	Months Days	Hours	IVIII I.	Oct. 17	1918	PA	
	p	Ī	Usual Residence of Decedent		140.00								10d. Inside City Limits
	thow	_	10a. State 10b. County			ty, Town or Lo							1 ☐ Yes 2x No
	Be-f.	cto	MD Balt	imore	T	imoniur							
	hours after death with the Maryland turel; or Itams 23a or 28e-f show al Exantrer must be multied at	Funeral Director	10e. Street and Number				10f. Zip Code			10	ng. Citizen of ' USA	What Coul	ntry?
	ath w	<u>ra</u>	300 Internatio				21030		211212	-4. 1/ 1/-		a Amari	can Indian,
	er de	nue	11. Marital Status	Armed F		J.S. 13. \	Vas Decedent of I f Yes, specify Cub	lispanic (an, Mexic	origin? (Spe an, Puerto	ecify Yes of No- Rican, etc.)		ck, White,	
30	s afte	by F	1 ☐ Never Married 2 ☐ Mar 37 ☐ Widowed 4 ☐ Divorced	ned 1 XYes If Yes, G	2□No Sive Dates: 39¹-	/ 5 1	I ☐ Yes 2 📉 No	Specif	fy:		Specif	y: W	hite
3	hour tural	B 1	41	nt's Education	Dates. 39 -		ent's Usual Occur	ation			16b, Kind of B	usiness/In	ndustry
ည်	filed within 72 Hygiene, sthar than "nef ent, the Modic	Completed	(Specify only highe	st grade completed		(Give	kind of work done	during m	ost of work				,
7	with ene.	Ĕ	Elementary/Secondary (0-12)	n/a	(1-4or 5+)	Aviat	ion Mecha	anic		1	Militan	ry Co	ntractor
0	e filed al Hygie othar		17. Father's Name (First, Middle,			1111 200			ther's Name	e (First, Middle, M			
<u>8</u>	should be nd Mental s marked o umatic eve	To Be	Nicholas Pramo	v				01	Lga Ne	euman			
Maryland 21215-0036	2 shou and M Is mar sumati	-	19a. Informant's Name/Relations			19b. Mailir	g Address (Street	and Num	ber or Rura	al Route Number,	City or Town	, State, Zip	Code)
	and 2 ealth a n 27 is		Mark A. Neuman	/son		4506	Snowy Eg	gret	Dr.,	Naples,	FL 34	119	
യ	- T = =		20a. Method of Disposition			Place of Dispo	sition (Name of natory or other pla	ce)	May	Date 2	20c. Location	- City or To	own, State
Ê	Page ent o nt: If ny or		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		n State Nar	les Me Gard	morial) 	201		Naple	s. FI	,
altimore,	permit. Pages Department of I Importent: If ite any injury or of once.	1	21. Signature of Funeral S		3.11		Name and Addre	ss of Fag	ility	- C D. 1			
ñ	Departing any ir		Michael Ja	Nagle		1 L	emmon Fui 0 W. Pade	nera. onia	Rd	Timoniu	n. MD	21093	, Inc.
			23a. Part1. Enter the disease, o	complications that	caused the dea							F	Approximate Interval Between
X (1)	Maria Maria	8 IU	shock, or heart failure. List Immediate Cause (Final	t only one cause on	each line.	Do .	T. 0	0 -	0.0.0	+			Onset and Death
r	Pnysician /Medical		disease or condition resulting in death)	a. Due to	o (or as a conse		Iron aus	n a		-cy			
	Examiner				,								
		e.	Sequentially list conditions, if any, leading to immediate	Due to	o (or as a conse	quence of):							
	uted d ansit	Examiner	if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events	S .									
E .	exec an an rial-tr		resulting in death) Last	Due to	o (or as a conse	quence of):							
87603	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical		d									
89	tifica ng ph as th	0											
Вох	h cer endir r use	J.	IF FEMALE: 23b. Was decedent pregnant		outcome of pregrebinth 2 Fet		Ectopic pregnanc	v				ate of deliv	very Day Year
m.	deat ne att	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of		Other (specify) _				IVI	OHU	Day
0.	at the by the	hy	9 Unknown						-				
s,	as the gned oe de	by Physician/M	Part II. Other significant conditi	ions contributing to	death but not re	sulting in the u	nderlying cause gr	ven in Pa	rt I.				the cause of death?
5	en si ould l	ed	Aypotportes	~ 1 0×10	egunia	-, 000	7 nous	els_		1 U Y6	s 2 No	3 🗆 Pro	babiy 4 Nonkhown
Division of Vital Records,	aw re as be 2 sho	Completed	undumo	zeel poss	ell un	dely "	termor			24a. Was a autops	v	Were aut	opsy findings available ompletion of cause of
ž	iician: The la certificate has rector, page 2	E		- ,		'				perform 1 ☐ Yes 2	ned?	death? 1 🗌 Yes	2 No
ā	ian: rtifica stor, p	Bec	25. Was case referred to medica	al				26. Pla	ace of Deat	h (Check only on	e)		
>	Physical this ce al direc	To	examiner? 1 □ Yes 2 ☑ No	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3 DOA	her:	Nursing Ho	ome 5 🗆 Reside	ence 6 □Ot	her (Speci	ify)
0	ng Ph ter th neral	ä	27. Manner of Death 1 SNatural 5 ☐ Pendi	/1.40	e of Injury onth, Day Year)	28b. Time o Injury	28c. Inju	ry at		28d. Describe ho	w injury occu	rred	
0	andin ath. or: Af	atlo	2 Accident invest	igation				Yes 2	□No				
<u>N</u>	er de recto	tific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	nined 286. Pla	ce of Injury - At I		eet, factory, office			28f. Location (St. City or Town		ber or Rui	ral Route Number,
ā	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filted in by the funeral director, page 2 should be detached for use as the burial-transit	Certification:											
	hour uner uner	cal	29a. Certifier 1 Certifyi (Check only 2 Medica	ng Physician: To t I Examiner: On the	he best of my kn	owledge, deat	h occurred at the t	ime, date	and place, death occur	and due to the cared at the time, d	ause(s) and mate and place	anner as	stated. to the cause(s)
	the F iin 24 tha F iplete	Medical	one)	and ma	anner stated.								
	To To I	2	29b. Signature and title of certifi	2			29c. Licen	se numbe	er	2	9d. Date sign	ea (Month) 5 - 10	, vay, rear)
			1 K.T. 9	ilily 10	w.		\mathcal{V}_{e}	714	64		J - 6	,-10	
	My/	}	30. Name and address of person	who completed ca	use of death (Ite			_ : -		<i>f.</i>			
	¥		KUBant UBE	uto, YW			le ST	219	197				
	Sta		31. Date filed (Month, Day, Year	32.	Registrar's Sign	nature							
	Registi	e: 1 e		1 WALKERY	TALL STATE	Act of the second							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Maryland /	Department of F		ental Hygiene .Reg. No.	2010	11.651
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	2/20		2	Date of Death	7890	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give stre	A	4b. City, Town, or	Location of Death	1 / - 8	County of Death	1
_/	Funeral		0 - 1 0 0 100 7	T. Age (In yrs. last bir	thday) If Under 1 Year	timore If Under 24 Hrs. 8	. Date of Birth	9. Birthplac	te (State or Foreign
	Director		247.38 365 14	7. Age (In yrs. last bir	Yrs. Months Days	Hours Min.	(Month, Day, Year)	(Country)	SC
	land show d at	tor	Usual Residence of Decedent 10a. State 10b. County		vn or Location			10d	Inside City Limits
	ie Mary ir 28a-f notifie	Direc	10e, Street and Number		39 Himore	•	10g Citi	izen of What Country	1 XYes 2 □ No
	s 23a c	Funeral Director	5514 Peerless.	Avenuel		207	10g. Oil	USA	
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hyglene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by		Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Yo No If Yes, Give Year or Dates.	13. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Specify n, Mexican, Puerto Ric Specify:	an, etc.)	14. Race - American Black, White, etc. Specify: Blace	
21215-0036	thin 72 hou sne. than "natu he Medical	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Seconday (0-12)	completed) College (1-4 or 5+)	a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired)	luring most of working	16b. Ki	nd of Business Indus	. 1
land 2	should be filed within 7: and Mental Hygiene. is marked other than aumatic event, the Me	To Be (9th grade 17. Father's Name (First, Middle, Last) Willie W. Nelso	<u> </u>	DVIVE	18. Mother's Name (F	First, Middle, Maiden S	Surname)	
Baltimore, Maryland	id 2 should salth and M n 27 is mai er traumat		19a. Informant's Name/Relationship (Type, Dunna Mar En/Dau	Print) 19	b. Mailing Address (Street &		Poute Number, City or		(e) 21207
nore	Page 1 and 2 s тепt of Health : ant: If item 27 ury or other tra		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	noval from State cemete	of Disposition (Name of ery, crematory or other place		I	cation - City or Town	I
altin	permit. Page Department of Important: If any injury or once.	1 0	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	1 Drui	22. Name and Address	ss of Facility Value	ann C. Greer	2 Funeral	services
ш	9 9 = 8 9		23a. Part 1. Enter the disease, or complica	tions that caused the death. Do		erty Road a. such as cardiac or re			21133 pproximate
F	hysician,		shock, or heaf failule. List only one of Immediate Cause (Final disease or condition	ause on each line.	- Can			ln.	terval Between nset and Death
	Medical Examiner		resulting in death)	Due to (or sa a consequence	of):				
	n #	Examiner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	of):				
	cate be executed physician and the burial-transit	Exan	Cause (Disease or iinjury that initiated events c. resulting in death) Last	Due to (or as a consequence	of):				
09,	ate be e ohysicia the bur	edical	d.						
P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending properties of the funeral director, page 2 should be detached for use as completed filled in by the funeral director, page 2.	Physician/Me	in the past 12 months? 1 Yes 2 No	If yes, outcome of pregnancy 1 Live Birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown		у		23d. Date of delivery Month Da	ay Year
<u>Ö</u>	at the ced by the		g ∐ Unknown Part II. Other significant conditions contr		in the underlying cause give	en in Part I.	23e. Did tobacco u	se contribute to the	cause of death?
ds, F	quires then signer and be	ted by					1 🗆 Yes 2	□ No 3 □ Probab	oly 4 Unknown
Recor	The law reate has be page 2 sho	Completed					24a. Was an autopsy performed?	death?	letion of cause of
ital	sician; certific irector,	Be	25. Was case referred to medical examiner? 1 Yes Io	pital:	Oth	ace of Death (Check or		[] OU (0)(5.)	
of	ng Phy fter this ineral d	ate: To	27. Manner of Death 1 → Natural 5 □ Pending	1 Inpatient 2 ER/C 28a. Date of injury (Manthy Day Year) 28b.	Time of 28c. Injury work	/ at 280	e Residence 6 d. Describe how injury		
Division of Vital Records,	or Attendi after death Director: A in by the fi	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, f building, etc. (Specify)		Yes 2 □ No 28	f. Location (Street and City or Town, State)		oute Number,
Δ	Hospital	Medical ((Check 26 Medical Examiner	n: To the best of my knowledge On the basis of examination and ractioner: To the best	or investigation, in my opinio	on, death occurred at the	e time, date and place,	, and due to the cause	
	No the	2	29b. Signature and title of certifier	soll	29c. License			te signed (Month, Da)	/, Year)
•	J		30. Name and address of person who com	pleted cause of death (Item 23a)	(Type, Print)	Abin	Bluck	55.68	121061
	Stat	te	31. Date filed (Workly, Day, Year)	32. Registrar's Signature	200	-1-11-2	11020	-20 11	. 0/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mayonth Sophie Margaret O'Connell 10:04^{Рм} 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Kensington Nursing Home Kensington Social Security Number 6. Sex If Under 1 Year 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F Days Hours 99 087-22-9979 Yrs. **Director** <u>05/5/1911</u> Usual Residence of Deceden 28a-f shov 10b. County 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Kensington 1 Yes 2XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3616 Littledale Road 20985 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or 1 Never Married 2 Married þ 1 ☐ Yes 2 🔯 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify:White Completed 3℃XWidowed 4 □ Divorced Year or Dates nit. Page 1 and 2 should be filed within 72 hour artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natur injury or other traumatic event, the Medical injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Operator Communications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stanley Paskol Rosalee (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10104 Irongate Road; Potomac, MD 20854 Alice Rosenberg, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Chesapeake Crematory 5/11/2010 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service MO1539 22. Name and Address of FacilityRapp Funeral & Cremation Svcs. Silver Spring. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Pneumonia Medical resulting in death) Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Univerlying Cause (Disease or iinjury Due to (or as a consequence of) physician and the burial-transit Atherosclerotic Heart Disease To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \subseteq \text{No} \) Day Pregnant at time of death Year 9 Unknown 9 🗌 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s performed? Yes 2 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) Hospital 1 \sum Yes 2 X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending neral Director; A filled in by the fu 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined hours after within 24 hours a To the Funeral Completed filled Medical 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated. xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Aja P. Ready MD; 31. Date filed (Month, Day, Year) 32. Registrar's Signatu

Registrar

29b. Signature and title of cer

impleted cause of death (Item 23a) (Type, Print)

29c. License number D53691

\$200 Tower Oaks Blvd. Ste 110 Rockville, MD 20852

29d. Date signed (Month, Day, Year) May 10, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Frank Opo1ko 2:55 MAY 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SINAI NISPITAL OF BALTIMINE BACTIMORE n/a 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Country)
MD **Funeral** (Month, Day, Y 1-√2 M 2 □ F Min Hours 217-09-5515 **Director** Jan. 1919 Usual Residence of Decedent 28a-f shov "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Baltimore Timonium 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2 Gurteen Ct., Unit 201 21093 USA 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 XYes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: white 3 X Widowed 4 □ Divorced traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be flied within 72 Department of Health and Mental Hygiene. "Important: If item 27 is marked other than " any injury or other traumatic event, the Mex ones." life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer 12 Bethlehem Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Constantine Opolko Mary Desauage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Garrett Opolko/son 2 Gurteen Ct. Unit 201, Timonium, MD 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 5/10/10 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Dulaney 4 Donation 5 Other (Specify) Valley Memorial Gardens Timonium, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Fadonia Rd., Timonium, MD 21093 Michael Carpenter 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, it may be a ling to make list cause. Enter Underlying Examine the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Year signed by the at Id be detached fo g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CARDIOGENIC SMOCIC Records, 1 Ves 2 □ No 3 □ Probably 4 □ Unknown Completed CORONARY ARTERY DISEASE 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? 2 700 Yes Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Physic within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral dire 1 🗌 Yes 2 1100 မ 1 Impatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2gb. Signature and title of certifie 29d, Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

State

Registrar

32. Registrar's

MUSPITAL OF BALTIMORE

	for State Registrar 1. Decedent's Name	e (First Middle				ficate of	Health and N		Reg. No	0 0	1465
cian lical	Jose	Gerr	ardo Puig					2. Date of De.	Day 6	Zo [O	3. Time of Death
iner	4a. Facility Name (/		give street and number)			BA H	more (CITY	4c. Co	ounty of Death ${ m N/A}$	1
l r	5. Social Security N 462-44-86	65	5. Sex 7. Ag 1 🙀 M 2 🗆 F	ge (In yrs. last 84		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da Sept. 2.	th Year) 3,1925	9. Birth Cou Puer	nplace (State or Fore Intry) To Rico
_	Usual Residence of 10a. State	Decedent 10b. County		10c. City, To	own or Locat	ion					10d. Inside City Lim
Director	Maryland 10e. Street and Nur		imore	0	wings	Mills 10f. Zip Code			10g. Citizer	n of What Cou	1 □Yes 2 🙀
eral		ncy Alle				211				d State	es
To Be Completed by Funeral Director	11. Marital Status 1 ☐ Never Marri		12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give			s Decedent of I es, specify Cub ¶Yes 2 □ No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:		- 1	Race - Amer Black, White, pecify: T31	, etc.
q pa	3 ☐ Widowed	4 ☐ Divorced 15. Decedent's	Year or Dates:		Sa. Deceder	nt's Usual Occu	Specify: Puert	to Ricar	16b Kind	of Business/Ir	
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-	19a. Informant's Na		o (Type. Print)	1:	9b. Mailing A	Address (Street	and Number or Run			own, State, Zi	ip Code)
	Juan Car1		/ Son				len Way, (
	1 ☐ Burial 2 5	Cremation 3	Removal from State	1		on (Name of ory or other pla	i	Date		ion - City or T	·
		5 ☐Other (Spenneral Service Line	censeeAmanda H		22. N	atory, ame and Addre	Inc.: May ss of FacilityCren	<u>/, 2010 </u> nation S	Baltu ociet	more, I	Maryland rvland T
Ü	She	ualo	I.		299	Freder	ick Road,	Baltim	ore, I	Maryla:	nd 21228
Medical Certification: To Be Completed by Physician/Medical Examiner	Immediate Cause (disease or condition resulting in death) Sequentially list concause. Enter Under Cause (Disease or that initiated events resulting in death) L	Final n n n n n n n n n n n n n n n n n n	b. Due to (or as	a consequence	e of): Y E	dema					Interval Between Onset and Death
Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal dea		ctopic pregnanc ther (specify) _	у		23d	. Date of deliv	very Day Year
5	^		s contributing to death b (Aぃcek	ut not resulting	in the unde	rlying cause giv	en in Part I.				the cause of death?
Completed	End ST	Age P	renal Di	sease				24a. Was autop perfor	sy med?	4b. Were auto prior to co death? 1 □ Yes	opsy findings availa ompletion of cause
Be	25. Was case referr examiner? 1 ☐ Yes 2 ☑	/	Hospital:	ent 2 ER/0	2.44:4	Oth	26. Place of Death				
Certification: To	27. Manner of Death 1 ☑ Natural 2 ☑ Accident		28a. Date of Inju (Month, Da	ry 28b	Time of Injury	28c. Injui Wor	y at k? Yes 2 □ No	me 5 ☐ Resid 28d. Describe h			ify)
Sertifica	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine			farm, street,	factory, office		28f. Location (S City or Tow	Street and N n, State)	umber or Run	al Route Number,
Medical (29a. Certifier (Check only one)	1 ☐ Certifying 2 ☐ Medical Ex	Physician: To the best taminer: On the basis o and manner sta	f examination a	ge, death oc and/or inves	ccurred at the ti	me, date and place, opinion, death occurr	and due to the red at the time,	cause(s) an	d manner as ace, and due t	stated. to the cause(s)
M	29b. Signature and	V//				29c. Licens	e number		29d. Date si	igned (Month,	Day, Year)
		ess of person wh	no completed cause of d	eath (Item 23a	ı) (Type, Prir	Doc	Hospit.		May	6,20	010
	FREDER	1.7	BURKE, JI	1 111			11	AI . (1)	1 - 11 .	A P

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 29d, per MD G903 5/11/10 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May **Physician** Alva Rummel Perry 2010 8:15PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Future Care Homewood Baltimore City Baltimore 8. Date of Birth (Month, Day, Y 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Year 913 1 □ M 2 1 F Months Days Hours Min. **21**8-**1**0-**7**826 96 Maryland Director Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Event has must be notified at 10d. Inside City Limits Director 1 □Yes 2 No **Harford** Fallston Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21047 1702 Chateau Court Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ▼No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: ≥ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit, Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important: If frem 27 is marked other that may injury or other traumant. 12 Librarian Library 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fredericka Kahler Albert Rummel ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1702 Chateau Court, Fallston, Henry J. Berg, Jr., Nephew MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May 6,2010 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service License Corse Cremation Society of MD., Inc 299 Frederick Road, Baitimore, Maryland 21228 23a. Part 1. Enter 1 disease, or complications that caused the death. shock, or (ear, failure. List only one cause on each line. Immediate Cau Final disease or condition a. Approximate Interval Between Onset and Death ENCEPHALOPATHY **Physician** /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown Ś signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Wunknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Hospital or Attending Physician: The this certificate 2 No 1 □ Yes 2 2 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes _ 2 **□** No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: 1 - Natural 5 Pending Injury n 24 hours after death.

le Funeral Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2

State Registrar

DHMH 17 Rev 1/2001

ho completed cause of death (Item 23a) (Type, F

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month a_M **JEANNE** PARKER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SUMMIT PARK HEALTH & REHAB. CENTER BALTIMORE CATONSVILLE 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 K F Min. Months Hours (Month, Pay, Year) 2/8/1934 Director 219-32-7774 76 Usual Residence of Decedent 3a or 28a-f show be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Y Yes 2 ☐ No HOWARD ELLICOTT CITY MD 10e. Street and Number 10g. Citizen of What Country? er than "natural", or items 23a the Medical Examiner must be Funeral within 72 hours after death with 11798 FREDERICK ROAD 21042 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? or i Black, White, etc. 1 Never Married 2 Married ò 21215-0036 1 Yes 2 No Specify: If Yes Give Specify: BLACK 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) US GOVERNMENT ADMINISTRATOR Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill timent of Health and Mental tant; If item 27 is marked ည WILLIWM RANDALL JEANETTE WILLIAMS traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES EDWARD PARKER/HUSBAND 11798 FREDERICK RD. ELLICOTT CITY, MD 21042 Department of Health Important: If item 23 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State BUSHBY PARK COM. CEM 05-15-2010 | COOKSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death h 15LOD SPLASTIC Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burlal-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 IMIA Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No After this certificate 1 Yes 2 No Hospital or Attending Physician; 26. Place of Death (Check only one) **Division of Vital** Be 25. Was case referred to medical Other: 4 Mursing Home 5 - Residence 6 - Other (Specify) 2 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 Yes 2 No after death Director: / Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) within 24 hours a To the Funeral D Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the Lastin of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: Talks best of my hours age of oth occurred at the time, date and place, and due to the cause(s) and manner contact. (Check the best of my knowledge. If eth continued at the time, date and place, and due to the caucage) and mainter ac etated 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 00061765 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TBENEQEA QUAINOOMD 3350 WILLCENS AVE #307 BALT. MD 21229

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland	•				nd M	lental Hy	/giene	201	0	116	,
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate	OT D	eatn	_	0.01. (0.	Reg. No	201	U	140	<u>J</u>
	Physicia		Maryann T.		Patti				2. Date of De Month	Da 7	y Yea	ar	3. Time of Dear	
6-7 -	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, To		ocation of	Death	May	1	2010 County of D		7:55A	M
-39	Z		1010 Stewart Lane N.E.		Glen			Deali			nne Ai		le1	
	Funeral	Г	5. Social Security Number 6. Sex 7. Age (in yrs. las	st birthday)	If Under 1	Year	If Under 2		8. Date of Bir	th .				eign
	Director		215-30-1160 1 M 2 M F 74	Yrs.	Months [Days	Hours	Min.	Sept.	28°,1	935	Birthpla Country	MD .	
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	he M or 28		Maryland Anne Arundel Co. G 10e. Street and Number	len Bu	10f. Zip Ci	ode				10a Cit	izen of What	Countr		TIVO
	with 1	eral	1010 Stewart Lane NE			210	60			_	nited :			
	leath tems er m	Funeral	11. Mantal Status 12. Was Decedent Ever in U.S.	13. V	vas Deceden	t of Hisp	anic Origin	n? (Spec	cify Yes or No-		14. Race - A	_		
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lan	should and h is ma		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (S	treet and	d Number (or Rural	Route Numbe	er, City or	Town, State,	Zip Co	de)	7
≥,	nd 2: ealth m 27		Mr. Joseph A. Patti / Husband	1010	Stewa	art	Lane	NE	G1e	n Buı	nie, l	MD	21060	
altimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Disposition 2 Dispos	ace of Dispos metery, crem	sition (Name of atory or othe	of r place)		D	ate	20c. Lo	cation - City	or Tow	n, State	
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Bal	perm Depa Impo any ii		21. Signature of Funeral Service Licensee										emation	
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	cate be executed physician and the burial-transit	alE	resulting in death) Last Due to (or as a consequent	nce of):										
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$\stackrel{\geq}{=}$	tal or rs aft al Dir ed in		building, etc. (Specify)					-	City or Tow	n, State)				
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination a	lge, death oc	cured at the	time, da	ite and pla	ce, and	due to the car	use(s) and	I manner as s	stated.	(a) and manner of	tetad
	thin 2 thin 2 the I		only one) Certifying Nurse Practioner: To the best of my ki	nowledge, de	ath occurred	at the tir	ne, date an	nd place,	and due to the	e cause(s)	and manner a	s state	d.	ated.
	₽.≥ ₽ 8		Lordo M www.		29c. Lic	FZP				29d. Date	signed (Mor	ith, Day	(, Year)	
		-	30. Name and address of person who completed cause of death (Item 23	3a) Time D							3/1	//2	2	
			Christopher de Borja, m. D	371	18 M	٦٨،	ntai	'n	Rol 7	200	rlom	m	02112	o
	State	7	31. Date filed (Month, Day, Year) 32. Registrar's Signature	e	- 11	, ,,	.,, \	·• I					0 - 1100	
	Registra	r	MAY 1 1 2010 6 A	n Ales										

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Apr 29, 2010 Year **Patterson** 7:30p Linda Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A 153 Collins Street **Baltimore** 5. Social Security Number 8. Date of Birth (Month, Day, Year) Feb 24, 1950 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Months Days Hours 1 M 2 F Director No. Carolina 213-54-2065 60 Usual Residence of Decedent 28a-f show 10a, State 10b. County injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yes 2 ☐ No **Baltimore City** Maryland 10e. Street and Number ō 10f. Zip Code 10g, Citizen of What Country? 23a Funeral U.S.A. 153 Collins Street 21229 items ; 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 YNO Yes If Yes, Give Year or Dates 1 Yes 2 XNo Specify: than "natural", Black Completed 3 Widowed 4 Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **Baltimore County Public** permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha Cafeteria Worker Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ည Catherine Williams Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 821 North Curley Street Baltimore, Maryland 21205 Karen Harris 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 05/07/10 Lansdowne, Maryland Mt. Zion Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility any Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death

3 4-Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a conseque Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last sician and burial-transit Exam Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the use as IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☑ No Pregnant at time of death should be detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s this certificate has autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☑ No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🔲 Yes 2 🗵 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury 28b. Time of After 4 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work 1 🗌 Yes Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, (Check within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) DD 2250 5 Jaros 114

State Registrar Name and

ss of person who completed

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cause of death (Item 23a) (Type, Print)

's Signature

Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 5:20 p /Medical <u>James Ernest Richardson</u> 2010 26 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Nursing Home n/a Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex Birthplace (State or Foreign Country) 1**⊠** M 2□ F Yrs. Director 10_19-63 218-74-0940 46 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show "natural", or items 23a or 28a-f shov edical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Baltimore Md. n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral USA 2700 N. Charles Street 21218 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 ☐ No 3 Widowed 4 Divorced Black Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Unk (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "r any Injury or other traumatic event, the Med once. than, Elementary/Secondary (0-12) College (1-4or 5+) 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Eugene G. Richardson Sarah M. McCrimmon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Edward Richardson</u> 20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

Date

20c. Location - City or Town, State Baltimore, 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Mt. Carmel Cem. 5-3-10 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part1. Enter me disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Interval Between Conset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Statue /Medical Due to (or as a consequence of): Examiner Tonsilas Sequentially list conditions, if a y, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of): attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed Vital 2 **N**o Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To o filled in by the funeral 27. Manger of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending Injury 1 V Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier (Check only one) completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Saluja 4-27-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month,

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Reisterstown RD,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 315 **Physician** Charlotte M. Rengstorff 05 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Cosedale Square 8. Date of Birth (Month, Day, Year)
March 13, 1933 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 □ M 2 □ XF 148-26-2234 77 Yrs. NJ Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, The Medical Experiment must be notified at MD Baltimore 1 ☐ Yes 2 No Middle River Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 705 Compass Road 21220 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □KNo White Specify: 2 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be finance and Mental F Be John Finck Margit Nyman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health au
Important: If Item 27 is
any Injury or other trau Robyn Clark /daughter 8673 Castlemill Circle Balto. MD 21226 20c. Location - City or Town, State Date 20a, Method of Disposition Holly Hill Cemetery 5/13/10 Baltimore MD 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. 21. Signature of Funeral Service Licensee Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Non small cell cancer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, teating to inductions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consultence of): Examine attending physicic n and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☑ No 5 Other (specify) P.O. s been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>۾</u> 1 ☑Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performe 1 ☐Yes 2 ☑No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD uman lav 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FrankLin Square Drive Baltimore, Maryland 21237 4000 Suman Kao

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31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh g 903 5-21-10 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 000 Month / Year Physician 19.34 AM SODINSON 2010 /Medical . Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner GNES TIMO K AL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 194 Birthplace (State or Foreign Country) (In vrs. last birthday) **Funeral** Months Days Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show 1 Ves 2 No Director MORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2122 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 To 10 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Tes 2 Till If Yes, Give Year or Dates: 1 Never Married 2 Married BlAck Baltimore, Maryland 21215-0036 1 □Yes 2 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Luc IAN Department of Health and Mental Hygis Important: If item 27 is marked other any Injury or other traumatic event, It once. 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surna Be Pages 1 and 2 should be f nent of Health and Mental 9 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Jural Route Number, City or Town, State, Zip Code) SAHO. Md. 21211 KODINSON SIENN TURNUE 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State ARBUHUS, 4 □ Donation 5 □ Other (Specify) 21. Sign ture of Funeral Service Licen ee SVC. mas 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one decisions s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ise on each line. Approximate Interval Between Onset and Death STROKE Immediate Cause (Final HEMORRHAGIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to initial date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. attending physician Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy for Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.0. detached 9 HInknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Records, 9 RATORV FALLURE 1X Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed PULMONARY 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 □ Yes 2 No Vital 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 XNo 1 npatient 2 ER/Outpatient 3 DOA Medical Certification: To ō 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred or Attending Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deatl To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mpnth, Day, Year) 23489 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVENUE BALTIMOREMD CARDO TUGUSTO (ONTI SLAIBI 31. Date filed (Month, Day, Y 32. Regis ar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 9^{Day} Physician/ May EDITH GREEN 2010 10:20A M ROSEN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 6214 Haddon Avenue Baltimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Director 160-14-2022 95 March 19, 1915 Pennsylvania Usual Residence of Decedent 28a-f shov 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 6214 Haddon Avenue 21212 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes XX No Specify: If Yes Give Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Musician Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leopold Green Rose Levin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR 6214 Haddon Avenue Baltimore, Maryland 21212 Lora Beth Rosen Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State GreenMount Crematory May 11,2010 Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) gnature of Funer 22. Name and Address of FaMfyTCHELL-WIEDEFELD FUNERAL HOME INC <u>6500 York Road Baltimore, Maryland 21212</u> 23a. Part 1. Enter the disease, or compli shock, or heart failure. List only or eations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death In on the S Immediate Cause (Final Physician/ ongestive disease or condition Medical resulting in death) Due to (or a a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami that the death certificate be executed Cause (Disease or imjury that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Unknown Unknown Division of Vital Records, P.O. cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy this certificate 2 No 1 Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40 21284 xander 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAILLIN Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 21:20 PM George Alfred Rhinehart, Jr. 0 5010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hornital Baltimore N/A Home 2 St. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Min. Hours 1**₾**M 2□F 214-26-0959 80 Director 4, 1929 Baltimore, MD Nov. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Intel filem 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, if a Modicel Exp. iii ar must be nothind at my or other traumatic event, if a Modicel Exp. iii ar must be nothind at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Directo Maryland| Anne Arundel Co. Millersville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8312 Watermill Drive 21108 Funeral United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 MYes 2 No 1951 If Yes, Give
Year or Dates: 1953 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. δ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Food Processing Co. 10 <u> Sheet Metal Mechanic</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Alfred Rhinehart, Sr. Ellen Connelly ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Betty Ann Rhinehart / Wife 8312 Watermill Drive Millersville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Glen Haven Mem. Park | 05/11/2010 | Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service L MO1121 Services PA; 1 2nd Ave SW; Glen Burnie,MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Conjestive **Physician** Heart 4 Peters disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner polmonam 40005 Evere Sequentially list conditions, if any, leading to influented cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed signed by the attending physician and I be detached for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown completely filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performe of Vital 1 ☐ Yes 2 ☐ No Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ပ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division **→** Natural 5 Pending 1 ☐ Yes 2 ☐ No Hospital or Attendi
 hours after death.
 Funeral Director: A investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) M.Q. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAITIMORE MHO NAMRAS KORDI: CATON 900 AVE. 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Yea 350 Medical Facility Name (if not institution, give street and number Town, or Location of Death Examiner 4c. County of Death Memoria 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 Months Min Director 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County notified at Director 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? Examiner must be old York by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Armed Forces Black, White, etc. Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 1 Tes 2 No Specify: Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) opnday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) ည Informant's Name/Relationship or Town, State, Zip Code) Baltimore, thod of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important; If ite
any injury or ot Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) . Si ature of Funeral Serv e License si'ces 23a. Part 1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ₽nysician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Chronic obstructive Sequentially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Aprtic stenosis the Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director, After this certificate has autopsy performe death? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: ၉ 1 🗌 Yes 2X No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) filled in by the funeral Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work' 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 1 Yes 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Murse Practionar To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AT2438946 EG MD 05, 06, 7010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkway 201 Janice FOST ()piversity 31. Date filed (Month, Day, Year) NAY 1120 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 10:02p Alfrazia Robinson May 9, 2010 М /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore Baltimore 3725 Patterson Avenue 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 M 2 □ F Months Director Maryland May 14, 1955 216-62-1770 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f shov ust be notified at 1 Yes 2 □ No Director Baltimore Baltimore Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21207 U.S.A. 3725 Patterson Avenue Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Exali d'inf Black. White, etc 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Black 3 Widowed 4 Divorced er than "natura" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Tax Advisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Selena Robinson Walter Robinson ဂ traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3725 Patterson Avenue Baltimore, Maryland 21207 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr Linda Robinson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, Maryland 05/11/10 Metro Crematory, Inc. 21. Signal Theral Service Ligenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician auso bo /Medical Due to (or as a consequence Examiner Sequentially list conditions, than, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner True to for as a consection or off or Attending Physician: The law requires that the death certificate be executed burial-tran Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) physician Physician/Medical the as attending use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown þ signed Partill. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò pe 1 Tyes 2 □ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has director, page 2 autopsy certificate 1 □ Yes 2 □4No 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\sum_{\text{Nursing Home}} \) Hospital 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) Certification: To this 27. Mannet of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

n 24 hours a the 0

> State Registrar

29b. Signature and title of

31. Date filed (Month, Day,

30. Name and address of person

ho,completed cause of death (Item 23a) (Type, Print)

Signature

32. Regis

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Exan	niner	The Johns Hopkins Hospital		Baltimore		Deam		N/	Α	
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last bin $217-54-4001$ 1 1 2 1 2 1 1 2 1 2 1 1 2	rthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birt (Month, Day ARCH	th y, Year) 30, 1949	Coun	place (State or Foreign try)
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Baltimo permit. Page Department of Important: If any injury or	ej l	4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	* 22	Name and Addres	s of Facility	CHAR	LES S.	ZEILER	& S(
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death cer attendined for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)				23d. Dat Mo	te of deliventh	ery Day Year
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To the Hospital or within 24 hours aft To the Funeral Di completely filled in	Medical C	29a. Certifier (check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and manner stated.	death d/or inv	occurred at the tim restigation, in my op	ne, date and pinion, deat	f place, and th occurred	due to the at the time,	cause(s) and ma date and place,	anner as s	stated. to the cause(s)
To th	M	29b. Signature and title of certifier		29c. License	number	594	L	29d. Date signed	(Month,	Day, Year)
		30. Name and address of person who completed cause of death (Item 23a)	(Туре,	Print)	υ υ <u>α</u>	00 1	- 12.	11111	<u> </u>	NAD 0400
	state	31. Date of Month, Day Gard Line 32. Registrary Signature	K			OUU NO	ortn WO	iie St, Ba	ıtımoı	re, MD, 21287
Regis	strar									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Menin 2010 11:45 F.M Ke1by L. Smith Medical 4a. Facility Name (if not institution, giverstreet and number) Examiner 4b. City, Tow 4c. County of Death more na Social Security Number 6. Sex 1 ♣ M 2 ☐ F . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** $\operatorname{Oct}^{(Month, Day, Ye)}$ Maryland Director 219-58-4578 59 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 10d. Inside City Limits 1 X Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must b Funeral 3601 Pinkney Road 21215 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian Armed Forces?
1 ☐ Yes 2 🖾 No Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 72 hours after 1 Yes 2 No Specify: Specify: White 3 Widowed 4 X Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Freelance Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Homer Jackson Smith Helen Marie Bopst 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole J. Kallens/ Friend 3601 Pinkney Road, Baltimore, Maryland 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pathent 1 🔲 Burial 2 😾 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 5/10/2010 |Baltimore, Maryland Metro Crematory, Inc. Signature of Funeral Service Licensee Aman a Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. Cel 299 Frederick Road, Baltimore, Maryland 21228 tal 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Due to (or ps a consequence of): disease or condition resulting in death) days Medical [√]Examiner 4 months notangiocarcinoma Sequentially list conditions, Que to for as a nonsequence of cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a, Was an autopsy performed? Yes 2 1 No prior to completion of cause of death?

1 Yes 2 No After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 ☐ Yes 2 V No 은 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) May 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) anagisti's eveleko 31. Date filed (Month, Day, Year) State

Registrar

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			For State		State of Ma	rylan	-			Mental	Hygie	ne2	10	1456
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination must be notified at once.		21. Signature of Fu		1800			. Name and Addr	ess of Facility St	erling	Ash	ton S	chwab	
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	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burn		29a. Certifier	1 Certifying Ph	ysician: To the best of	my know	vledge, death	occurred at the	ime, date and plac	e, and due t	o the caus	se(s) and m	anner as s	stated.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G903,5.26.2010, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month (**Physician** 201 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Good Samaritan Nursing Home Baltimore City
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 218-22-8580 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Year 1□ M 25√F Yrs. Director PA April Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours attar death with the Maryland Department of Health and Mantal Hygians. Important: If Item 27 is marked other than "natural", or Iteme 23s or 28s-1 show any injury or other traumatic event, the Madical Exemina 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 TYes 2 □ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6008 Completed by Funeral York Road 21212 **USA** 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unknown Self employed Outdoor amusement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Bob Stevens <u>Anne Eli</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Stevens 20b. Place of Disposition (Name of cemetery, crematory or other place)

1204 Dullaney Vally Road, Towson ND 21236
20c. Location City or 1 20a. Method of Disposition 1 SyBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Western Cemetery . Mr. 22. Name and Address of Facility May.6,2010 Baltimore MD 21. Signature of Funeral Service Licensee Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road Lansdowne MD 21227 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Probable Onset and Death 140 Carde **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s tha burial-transit Due to (or as a consequence of) Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 22 NO 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification; To this eral Director: Aftar th fillad in by the funaral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

complataly filled 1 Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year)

V

To the Hospital or Attending Physician: The law requires that the death cartificate be executed

death.

aftar

Division of Vital Records, P.O. Box 68760

31. Date filed (Month, Day, Year) State Registrar

CHIANCE

5601 Loch Ravon Bluc Baker 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

158570

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 9 Physician/ Schrecengost Mary G. 2010 13:38 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore <u>Genesis Eldercare - Heritage</u> Dundalk Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) April 7, 1933 **Funeral** 9. Birthplace (State or Foreign Months 1 M 2 X F Country) Director 404-44-1375 Kentucky Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director New Jesey Bergen Dumont 1 Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 07628 USA 107 2nd Street items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ō þ 1 Never Married 2 Married Yes 2 XNo Yes, Give X Maryland 21215-0036 1 Yes 2 X No Specify: White Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Law Office 12 years Secretary injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be t Department of Health and Menta Important; If item 27 is marked Tylene Pitzer Herman Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 2 nd Street, Dumont, NewJersey Jeffrey Schrecengost son 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🎇 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) May 14,2010 Hopkinsville, KY Hale Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. any 7110 Sollers Point Road, Dundalk, Md. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CORYNARY Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine sician and burial-transit that the death certificate be executed resulting in death) Last attending physician Physician/Medical the IF FEMALE ase 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown jo Month Year Pregnant at time of death been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 Records, Completed 1 Yes 2 No 3 Probably Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has build sector, page 2 s autopsy performed death? 1 🗌 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ျှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. (Month, Day, Year) Natural 5 Pending work's Investigation 1 🗌 Yes 2 🗌 No Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State

DHMH 17 Rev 7/2009

Registrar

(Check only one)

29b. Signature and title of certifie

Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3.

29d. Date signed (Month, Day, Year) 5-10-10

Dundalle MD 2/222

29c, License number

10-03522 Phillip A. Shimboff Ple

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	State of Maryland / Department of Health and Mental Hygiene	6	U I	U		4	6	1

		1- For State Registrar		Cert	ificate of	Death			Re	g. No.		
Physici		1. Decedent's Name (First, Midd	dle,Last)					2.	. Date of Death	1		3. Time of Death
Medical Exam	ner	Phillip	Andrew	Shimbo	off				Month May 6, 201	Day Yea	"	1645 hrs
		4a. Facility Name (if not instituti Susquehanna River	on, give street and number	er)	4	b. City, Town, o		f Death		4c. County of Harford	of Death	
Funeral		Social Security Number	6. Sex 7. A	age (In yrs. las	t birthday)	If Under 1 Ye		r 24Hrs.	8. Date of Birth	(MM/DD/YYYY	9. Birth	place (State or Foreign
Director		340.62.8591	1. M 2 F	49	Yrs.	Months Da	ays Hours	Min.	03.06		Cou	ntry) CA
any		Usual Residence of Decedent 10a. State 10b. County		Inc City T	own or Location	nn.						10d. Inside City Limits
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more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. unt: If item 27 is marked other than "natural", or items 23a or 28a-f show r other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number Chinquapin 50 Chinqwapi	n Trail			17314				g. Citizen of Wr U . S . A .		ry?
th with	eral	11. Marital Status 1 Never Married 2 N	12. Was Decede		13. Was	Decedent of H	lispanic Origi	in? (Spec	ify Yes or No-	14. Race White		an Indian, Black,
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ours a atura	d by	15. Decedent's Education (Spe	or Dates: ecify only highest grade co		6a. Decedent	's Usual Occupa	ation (Give ki			16b. Kind of Bu		
72 h 72 h gal En	ete	Elementary/Secondary (0-12)	College (1-4 o	r 5+)	during mo	st of working life	ie. DO NOT u	use retired)			
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygene. Tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	Completed	12	4		Super	visor				Ikea	War	ehouse
Hygi		17. Father's Name (First, Middle		_			110000			aiden Surname)		
121 d be f fental larke	o Be	Christopher 19a. Informant's Name/Relations	Shimbof	<u>f</u>			Mary		Burton			
Baltimore, MD 21215-005 permit. Pages I and 2 should be filed within Department of Health, and Mental Hygiene. Important: If item 27 is marked other thingury or other traumatic event, the Med	۲									er, City or Town		
and 2 ealth em 2		Donna Shimbo	off/Wife	20b Pla		ion (Name of ce				ta, PA		
Baltimore, permit. Pages I ar Department of Hee important: If ite njury or other tr		1 Bunal 2 Cremation	n 3 Removal from S	state cre	matory or othe	er place)	,				•	
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Balt permit. Depart Import injury		21 Signature of Funeral Service	Rilling	61443) 22. Na	ome and Address	ss of Facility een P	CAFA	/Step	hen D. r. BAİ	Lo.	hrmann,PA , MD
Physician		23a. Part Lenter the disease, or failure. List only one cause	complications that cause	d the death. D	o not enter the	e mode of dying	, such as car	rdiac or re	spiratory arres	t, shock, or hea	rt	Approximate Interval
/Medical Examiner		Immediate Cause (Final disease	5									Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a cons	sequence of):							$\overline{}$	-
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	nine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	sequence or):								
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876 tifical ng ph	_	23b. Was decedent pregnant in the	23c. If yes, outco	me of pregnar	₂ Feta	I death 3	Ectopic p	oregnancy		23d. Date of o	delivery Day	y Year
Box 687 e death certifi the attending ed for use as t	Physicia	past 12 months?	4 Pregnant a	t time of death		er (Specify)					20,	, , , ,
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that the d ned by the	b P	Part II. Other significant condit	ions contributing to dea	th but not resu	Iting in the un	derlying cause	given in Part	1.				e cause of death?
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cords law requi has been s	Completed								24a. Was an autopsy			osy findings available npletion of cause of
Reco	E					_	-		perform 1 ✓ Yes 2		eath?	2 No
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Vita hysici this c	0	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpati	ent 2 EF	VOutpatient	3 DOA	Other 1	Nursing H	ome 5 Re	esidence 6 🗸	Other: S	icene
n of ding Ph. After t	إغ	27. Manner of Death	28a. Date of Inj (Month, Day) May 1, 2010	ury 28 Year)	b. Time of Inju	ury 28c. Inju	ry at Work?			w injury occurre	d	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death. Tail Director: After this certificate has been signed by led in by the funeral director, page 2 should be deated.	Certification:	Natural 5 Pend 2 Accident Inves	May 1, 2010	1	722 hrs	1 1	Yes 2 🗸 N	loui	bject drowr	iea in river		
VISI or Ath after da Direct in by	읣			njury - At home	, farm, street,	factory, office b	building, etc.	28f			or Rural	Route Number, City
Divi	9	4 Homicide	mined (Specify) Riv	/er				Sus	or Town, Stat squehanna R			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exa	nysician: To the best of m miner:On the basis of exa	ny knowledge, mination and/	death occurre	d at the time, da	ate and place	e, and due	to the cause(s	s) and manner a	s stated.	equec(c)
To t with To t	Medical	29b. Signature and title of certifie	and manner stated.	- Introduction direct	or investigation	29c. Licens		in ed at the				
) vot	. 41 11 -	10		O.C.I				9d. Date signed May 7, 2010	•	, vay, rear)
	ļ	Hanely V	Ly Mell, M.	4)	,					viay 1, 2010		
		30. Name and addless of person Pamela E. Southall, M		,		Penn Stree	t, Baltimo	re, MD	21201			
St	ate	31. Date filed (Month, Day, Year)	- 30-	r's Signature								
Regist	_		110 Bure	1 B.	hare	P						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month Day Bernard Schulz 2010 Medical Mav 2:45A 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 768 South Mesa Road Millersville Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Days Month, Day, Y Sept. 4 Hours Min Country) 217-40-5811 Director 66 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location with the Maryland **Funeral Director** 10d. Inside City Limits MD Anne Arundel Millersville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 768 South Mesa Road 21108 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. <u>م</u> 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Gas Station Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bernard R. Schulz Grace A. Meyers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it. Page 1 and 2 sh utment of Health ar ortant: If item 27 is Mrs Connie Schulz/ Wife 768 South Mesa Road Millersville, MD 21108 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 13. cemetery, crematory or other place) 5 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2010 Atlantic Crematory Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licenses Services PA 1 2nd Ave. SW Glen Burnie. 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RESPIRATOR disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death signed by the a Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed cate has been significated by page 2 should be 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) Certificate: Manne of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniurv 1 Matural 5 Pending work: 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arun Bhandari M.D. 2003 Medical PKWY Suite G60 Annapolis,MD 21401 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Lorraine M. Spahn May 2010 8:25 \mathbf{P}^{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Baltimore Towson Birthplace (State or Foreign Country)
 Maryland Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex . Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Funeral 1 □ M 2 🗶 Months Days 89 216-14-0265 Yrs Director May 5, Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Baltimore Parkville 1 🗆 Yes 2 🔀 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2508 Hillcrest Avenue 21234 United States Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by "natural", or 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. Specify: White 3 Divorced 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 12 Sales Clerk Candy Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ဂ္ Joseph E. Barbour Certrude Poplar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S James C. Spahn, Sr. - Spouse 2508 Hillcrest Avenue, Parkville, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot Date cemeter, crematory of other place)
Evans Funeral Chapel and
Cremation Services Belair 1 Burial 2 X Cremation 3 Removal from State May 10, 2010 4 Donation 5 Other (Specify) Forest Hill, Maryland 21. Signature of Funeral Service Licent 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services 8800 Harford Road, Parkville, Maryland 21234 WA Parkville 23a. Part 1. Enter the disease, or conshock, or heart failure. List only inplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ +12heimer's dementes disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live land 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 2 No Yes 2 1 Tyes Division of Vital Be 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) 1 Yes DNo Hospital Other: ပ HO50 00 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Mapner of Death 28a. Date of injury (Month, Day, Year) Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending after death. M Accident Investigation the 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registra

31. Date filed (Month, Day, Year)

32. R. gistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 8 per fh g903 5-13-10 vt
State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mary	-	rtificate of E			glerie Reg. No. 🦳 🏌	110	11.671.				
	Physicia	ın/	1. Decedent's Name (First, Middle, I Helen Ri					2. Date of Dea Month	Day	Year	3. Time of Death				
	Medio Examir	al	4a. Facility Name (if not institution, g			4b. City, Town, or	Location of Death	May	10, 4c. Cour	2010 ty of Death	1:15 A M				
1	}		Oak Crest Car			Parkv	ille		Ba	ltimor	9				
	Funeral Director		5. Social Security Number 215-18-9185 Usual Residence of Decedent	7. Age <i>(ln y</i> 1 ☐ M 2 🔀 F	rs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Monit 8) June 26	h (, Yea <i>r</i>) , 1922	9. Birthp Co <i>uni</i> Ma 1	elace (State or Foreign try) C yland				
	rland f show	į	10a. State 10b. County		. City, Town or Lo	cation ville	-			1	0d. Inside City Limits				
	e Mary r 28a-i notifie	Direc	10e, Street and Number	imore	Park						1 Yes 2X No				
0	th with th ns 23a o must be	neral	8800 Walther			10f. Zip Code 2123			U.S.A.		try?				
-) Exp 5/10/10 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturalr, or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 🏋 Widowed 4 □ Divorced	If Yes, Give Year or Dates.		Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No- Rican, etc.)	ВІ	ace - America ack, White, e	etc.				
% 215-(72 ho an "nat	mple	15. Decedent's (Specify only highest	grade completed)	(Give	dent's Usual Occupa kind of work done o O NOT use retired)	ation luring most of work	ding	16b. Kind of		lustry				
	within ygiene her th		Elementary/Seconday (0-12)	College (1-4 or 5+)		Secreta:	ry		Med.	ical					
1154m -> Maryland 21	ld be filed Mental He arked ott atic even	To Be	17. Father's Name (First, Middle, Las Louis J. McC				18. Mother's Nam	ne (First, Middle, I e McMan n		me)					
Σ	nd 2 shou ealth and m 27 is m		19a. Informant's Name/Relationship Dennis Smith,	(Type, Print) Son		ng Address (Street a O Glenwo									
ກ ປາເ Baltimore,	Page 1 ar tment of H tant; If iter jury or oth		20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from State E	Pol :	natery or other place cal Chape Vir	i		20c. Location Rosest I	Hill, MI					
fr,	permit Depar Impor any in		21. Signature of Funeral Service Lic-	ense Claud)	Name and Address Nans Fund 300 Harfo	eral Chacility ord Rd.	apel & C Parkvil	rematica le, MD	on Services 21234					
Smi the			28a. Part 1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final	y one cause on each line.			g, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death				
3.	Ph_sician/ Medical		secte or condition recting in death)	de diate Cause (Final condition ting in death) a.											
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^س ر 8760	ificate be ng physic as the bu	edica	•	d				_							
رمال Box 6.	ath certif attending for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 ☐ Live Birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		- 1	Date of delive	ry Day Year				
9185 922 ds, P.0	requires that the de been signed by the should be detached		Part II. Other significant conditions Pneumonia,		resulting in the u	nderlying cause giv	en in Part I.		bacco use cor 'es 2		e cause of death? ably 4 \square Unknown				
18-91 128 (192 Records,	Physician; The law red this certificate has be ral director, page 2 sho	Completed by						24a. Was a autop: perfor 1 Yes	sy	were autop prior to cor death? 1 \(\sum \) Yes	sy findings available npletion of cause of				
85.57 Vital	ician; certifica	Be	25. Was case referred to medical examiner?	Hospital:		26. Pla	ace of Death (Chec								
S S S	Attending Physician; or death. ector. After this certific by the funeral director,	e: To	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 Inpatient 2	28b. Time of	at 3 □ DOA 2 28c. Injury	4 Nursing Ho	ome 5 Residence 28d. Describe ho							
	eath. or; Afte the fun	Certificate:	1 Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could no		injury	M 1 🗆	? Yes 2 🗆 No								
√ S S Division	tal or Att rs after d al Direct ed in by 1		4 Homicide determine		t home, farm, stre ecify)	e, farm, street, factory, office 28f. Location (Street and Numb City or Town, State)					Route Number,				
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director, After thi completed filled in by the funeral	Medical	(Check 2 Medical Exa	hysician: To the best of my knuminer: On the basis of examination of Profilement To the basis	ation and/or invest	igation, in my opinio	n. death occurred a	t the time date an	nd place, and d	ue to the cau	se(s) and manner stated				
	To 1 With Com		29b. Signature and title of certifier Michealle 9-	ocompleted cause of death (in crison CRNP MS) 2010 32. egistrar's Signatur	MSW	29c. License	number // 944	2	29d. Date sign 5/10/20	ed (Month, D	lay, Year)				
	12		30. Name and address of person when Micheelle G. Ha	ocompleted cause of death (I	tem 23a) (Type, F	Print)	.1 0 1		2/02						
	Stat	9	31. Date filed (Month, Day, Year)	2010 32. egistrar's Sig	onature V	WITH PIN	a, facky	Ile. MD	21234						
	Registra		MAILL	2010	/ //										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** RAYMOND A. SZCZEPANSKI 14:13 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GOOD SAMARITAN HOSPITAL BALTIMORECITY BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | July 19,1940 5. Social Security Number 213-34-4640 7. Age (In yrs. last birthday) **Funeral** 69 1X M 2 ☐ F MD Director Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 28a-f ehow other traumatic event, the Mudical Examiner must be notified at MD Baltimore 1 1 Yes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23a or 3518 Frankford Avenue 21214 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. or iteme 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo White þ Specify: Specify: 3 Widowed 4 Divorced "neturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiene Important: If item 27 is marked other theneny injury or other traumatic event, Item Ma Elementary/Secondary (0-12) College (1-4or 5+) 12 2 Counselor Research Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alexander Szczepanski Eugenia Binick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Madeline Szczepanski/Wife 3518 Frankford Avenue, Baltimore, MD 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State Final Journey Crem. 5/8/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) A Euneral Service Licensee Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services PO BOX 1413, Baltimore, MD 21203 Approximate Intervat Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition MYOCARDIAL INFARCT Physician /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dualto (or as a consequence of): Examine burial-transit and resulting in death) Last Due to (or as a consequence of) the attending physician P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Cher (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ INTRA ABDOMINAL ABSCESS 4 Unknown 1 🗌 Yes 2 🗆 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1□ Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1: Inpatient 2 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) zhhhu Res 5/4/2010 009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

DHMH 17 Rev 1/200:

31. Date filed (Month, Day, Year) NAY 11 2010

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LOCH RAVEN

r's Signature

BLV D, BALTIMORG

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Harry Maurice Sutt 2010 12:40 PM Medical Mav Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Towson Baltimore Gilchrist Social Security Numbe 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth OCT • 25 1921 Funeral Birthplace (State or Foreign Country)
 Ohd 1**X** M 2 □ F Hours Ohio Director 401-26-7608 88 Usual Residence of Decedent 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Timonium MD 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 2501 Girdwood Rd. USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. Completed by 1 Never Married 2X Married 1 X Yes 2 □ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the Managerian or other traumatic event the Manageria Elementary/Seconday (0-12) College (1-4 or 5+) Railroad Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nell Massie Raymond G. Sutt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2501 Girdwood Rd., Timonium, MD 21093 Esther V. Sutt/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 5/8/10^{Date} 20c. Location - City or Town, State 1X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Memorial Gardens Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Li 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Rd., Timonium, MD 21093 Michael J. Flagle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner frany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown page 2 should Were autopsy findings available 24a. Was an has prior to completion of cause of death? performed? Yes 2 No certificate 2 No 1 Yes 25. Was case referred to medical B 26. Place of Death (Check only one) 1 🗀 Yes 2 **W**No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) Was DCC 1 Inpatient 2 ER/Outpatient 3 IDOA Director: After this in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 24 hours after do Funeral Directo leted filled in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) License number X

O State Registrar

6 101

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4:05 A Everett Post Strickland May 6 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Baltimore Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Feb. 10, 1931 **Funeral** 9. Birthplace (State or Foreign Months Days Hours Director New York 073-26-6701 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b, County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland **Baltimore** Timonium 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral 11953 Mays Chapel Road 21093 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 KD Yes 2 Do No
If Yes, Give 1952-1955
Year or Dates. Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ YNo Specify. 3 - Widowed 4 - Divorced Specify: Completed White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Aircraft 4 Electricial Engineer Landing Systems Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Strickland Ray Marion R. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruric L. Strickland Brother 7148 Lake Avenue Williamson, New York 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 2 ☐ Donation 5 ☐ Other (Specify) 5-7-2010 Hilltop Service Corp. Towson Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Si nature of Jun <u> 1050 York Road</u> Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) Director: After this certificate has been signed by the attending physician and it in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Month Year 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: မ HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pendina Investigation 1 ☐ Yes 2 ☐ No 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1/20 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEUE DOBELAMANIMA GFOI NONAFLES ST, 8WTE405 BALTIMOTE, MD 21204 31. Date filed (Month, Day, Year) State Registrar

			1 - For State Registrar	State o	f Maryland		artment of H	lealth and M Death	-	giene Rag. No.	10	14678	
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1	Examir	ner	Riverview Nurs		11001)		Essex	Location of Death			Ltimor	e	
	Funeral	Wh.	5. Social Security Number	6. Sex	7. Age (In yrs. last	t birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h		lace (State or Foreign	
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	and and		Usual Residence of Decedent 10a. State 10b. Count	у	10c. City, T	Town or Lo	cation	<u>. </u>			1	0d. Inside City Limits	
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21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Itam 27 ia markad othar than "natural", or items 23a or 28a-f ahow othar traumatic avant, the Madical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Ma 3 【XWidowed 4 ☐ Divorce	rried Armed Fo	2 X No ∕e		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ace - Americ ack, White, ify: Wh		
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Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic avant, Ira Mannes.		19a. Informant's Name/Relation					and Number or Rura					
	and lealth m 27 har tr		Thomas Stray,	Jr Son				et Baltim	-				
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ţi	permit. Pa Departmen Important: any injury		`4 ☐ Donation 5 ☐ Other (21. Signature of Funeral Service		\$t.s		Slaus Ceme	etery 05/	13/2010	Baltin	nore,	Maryland	
Ba	permil Depar Impor any in	ļ	21. Signature of Fuller at Service	e cicerisee					ral_Hom	es P.A.	Moses I	~~ā 21221	
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	Examiner	L	Sequentially list conditions.	b									
	ed sit	dlcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	or as a consequen	nce of):							
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	To tha Hospital or Attending Phys within 24 hours after death. To tha Funaral Diractor: After this completely filled in by the funeral di	Medical (29a. Certifier 1 Cartify (Check only one) 2 Madica	ing Physician: To the Il Examinar: On the band man	best of my knowle asis of examination ner stated.	edge, deatl n and/or in	occurred at the tin vestigation, in my o	ne, date and place, pinion, death occurr	and due to the e	cause(s) and r date and place	manner as st e, and due to	ated. the cause(s)	
	To the within To the Comp	Σ	29b. Signature and title of certifi	er M-D			29c. Licenso	38754		29d. Date sign 25 – D	9-2		
			30. Name and address of person	who completed caus	e of death (Item 23	3a) (Type,	Print) B	WD,	M.9-	- 212	21		
	Sta		31. Date filed (Month, Day, Year		egistrar's Signature								
DH	Registi MH 17 Rev 1/2		MAY 1 1 2010	Beneva	A. pa	the							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 12:55 AM Helen E. Thomas 00 2010 05 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death HEALTHCATE BAUTIMORE SAINT AGNES If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Aug. 9, 9. Birthplace (State or Foreign Country)
New York 6. Sex 7. Age (In yrs. last birthday) Min. Months Days Hours 1 □ M 2 🗓 F 073-05-2298 95 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐Yes 2 X No MD Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6012 Black Friars Circle 21228 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11, Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 🔀 No Specify: White Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Piston Ring Inspector Aircraft 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stanislaw Brazis Amelia Bartasevica 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony S. Thomas Son 6012 Black Friars Circle-Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition W Burial 2 ☐ Cremation 3 ☐ Removal from State Lake View Mem. Park 5/14/2010 Sykesville, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Liver 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): 10 hrs Aspiration Menmoni Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 - Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

68760 P.0. Records, OMAS Vital ot

Division

To the Hospital or Attending Prnyswam. within 24 hours after death.

To the Funeral Director: After this certifict completely filled in by the funeral director, I

State Registrar

Physician

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Certification: To

Medical

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Expiriting 1. Let the netiting at once.

Physician

/Medical **Examiner**

attending physician

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certificate

Baltimore, Maryland 21215-0036

/Medical

29b. Signature and title of certifier MD 29c. License number D0068107

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 South MO

Caton Avanue Baltimore, MD 21229

31. Date filed (Month, Day, Year) 32. F

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. mend #30 per DVR g903 5/11/10 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Month 05 Physician/ 9:20 A M 2010 Medical cility Name (if not institution, give street and number Town, or Location of Death 4c. County of Death **Examiner** timore If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min 1 M 2 K Director or items 23a or 28a-f shov miner must be notified at 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral omia 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married within 72 hours after 1 ☐ Yes 2 No Specify: 3 Divorced Year or Dates. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a, Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) JOEANNA Be (Maryland ther's Name (First, Middle, Maiden Surname ၉ or Rural Route Number. 19b. Mailing Address 25 Baltimore, Burial 2 Cremation 3 Removal from State THOMAS 4 Donation 5 Other (Specify) 21. Signature of Funeral Servi Nas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final ISCHEMIC BOWEL Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner MELLITUS DIABETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours atter death.

To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the Inneral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death 2 110 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERLIPI DEMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No Yes 2 1 Be (25. Was case referred to medical 26. Place of Death (Check only one) 2 1 No Hospital Other: 1 Tes Certificate: To 1 Unipatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d, Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No. 5 Pendina Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000 05/06/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOOD SAMARITAN HOSPITAL LOCHRAVEN BLUD BALTIMORE, Ram H. Belbase 5601 31. Date filed (Month, Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	tate of Maryland		artment of H <i>tificate of D</i>		Mental Hy	giene Reg. No. 20	10 1468	3 1
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	Medic	al	Lena E. 7	Thomas				May	Day 7	Year 1:17 F	> _M
	Examin	er	4a. Facility Name (if not institution, give street Secours	t and number)		4b. City, Town, or Baltin		ith	4c. County	of Death	
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hr Hours Mir			9. Birthplace (State or For	reign
	Director		246-54-9669 1 □ M Usual Residence of Decedent	² XXF	76 Yrs.	Months Days	Hours		1934	NORTH CAROLI	NA
	show at	or	10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Lin	mits
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Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Certificate:	4 Homicide determined	 Place of Injury - At hom building, etc. (Specify) 	ne, farm, stre	et, factory, office		28f. Location (S City or Tow		er or Rural Route Number,	
Ω	spital		29a. Certifier 1 Certifying Physician	: To the best of my knowled	dge, death o	ocured at the time, of	date and place,	and due to the car	use(s) and manne	er as stated.	
	the Ho lin 24 b the Ful opletec	Medical	(Check 2/ Medical Examiner: 0 only one) 3 Certifying Nurse Pra	On the basis of examination a	and/or investi	gation, in my opinion	i, death occurred	at the time, date a	ind place, and due	e to the cause(s) and manner s	stated.
	To t To t		29b. Signature and title of certifier	2. 100		29c. License	10 1-		29d. Date signed	(Month, Day, Year)	
		ŀ	30. Name and address of person who compl	eted cause of dooth (Items 6	23a) /Turno Pr		6267		Thy	t, 2010	
			30. Name and address of person who compl	2000 W. 3	eltimor	C+	Baltin	ore MI	0 2	1223	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f sho injury or other fraumatic event, the Medical Examiner must be notified at once.	욘	19a. Informant's Name/Relationship Deborah Ann Steplock						nber or Rural Ro Baltimore		City or Town, Sta 230	ate, Zip Code)
e, M 1 and 2 Health item 2		20a. Method of Disposition			ace of Disposi ematory or oth	tion (Name o		Date	<u> </u>	. Location - City	or Town, State
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Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Signature of Funeral Service Lice	ensee				ress of Facilit	McCully P	olyniak	Funeral I	Home P.A.
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D.O. By that the de ned by the detached f	日	Part II. Other significant conditions	9 Unknown contributing to death b	ut not resu	ulting in the ur	nderlying cau	ise given in Pa	art I. 236	e. Did tobacc	o use contribute	to the cause of death?
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Division of Vital Records, I tal or Attending Physician: The law requires rs after death. al Director: After this certificate has been sighed in by the funeral director, page 2 should be led in by the funeral director, page 2 should be	Completed							24a	a. Was an autopsy performed?	prior to	autopsy findings available completion of cause of
tal Rec cian: The l certificate l	5	25. Was case referred to medical				20.0			Yes 2	No 1 🗸	
Vital hysician this cert	o Be		Hospital: 1 Inpatient	2 EI	R/Outpatient		Other4	(Check only one) Nursing Home		dence 6 🗸 Oth	ner: Scene
n of ling Ph After t funeral	l ii	27. Manner of Death	28a. Date of Injury (Month, Day,Year) 2	8b. Time of In	jury 28c.	Injury at Work		scribe how in	njury occurred	
ivisior or Attencafter death Director:	catic	2 Accident Investiga	28e Place of Injur	v - At hom	e farm street	factory offi	Yes 2	-	ation (Street	and Number or E	Rural Route Number, City
Division of Vital Rec pital or Attending Physician: The I ours after death. reral Director: After this certificate I filled in by the funeral director, page	Certification:	3 Suicide 6 Could no determin	t De	, , , , , , , , , ,	o, ram, 5000	i, idotory, om	ce ballaling, et		fown, State)	and Number of 1	tural Notice Number, City
Di To the Hospital within 24 hours: To the Funeral	ı ~ ı		cian: To the best of my ker:On the basis of examin								
To the To the Comp	Medical	29b. Signature and title of certifier	and manner stated.	ation and	701 IIIVestigati		ense number			. Date signed (N	
		Cauce	Halla			- 1 -	C.M.E.		100	y 10, 2010	
12		30. Name and address of person who				Annel D.	Um	24204			
	tate	Carol Allan, MD Assist	ant Medical Examination 32. Registrar's			treet, Bal	imore, MD	21201			
Regis	tate	WAT 1 2010	Lever 1	1 4	Darke						

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) 3. Time of Death Day Mouth **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days **Funeral** 1 □ M 2X F 79 189-24-9396 6-13-1930 Director S.C. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Director MD Baltimore na 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 200 St. Matthews Street 21202 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 In It Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify ģ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Housewife 6th grade Home na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Myers Ida Washington ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Alexander Whiting-Husband 200 St. Matthews Street Balto, MD 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 5-14-2010 Carmel Cem Balto, MD 4 Donation 5 Other (Specify) March East 21. Signature of uneral Service Licensee 22. Name and Address of Facility 1101 E. North svenue Balto, MD 23a. Part 1. Eriter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Day Month Year in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 🗌 Yes 2 1 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient Other: 2 ER/Outpatient 3 🗌 DQA 4 🗌 Nursing Home 6 Other (Specify) 5 Residence မ this 27. Man r of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending investigation M 1 Yes 2 No of Funeral Director: Alphetely filled in by the fi 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIFFANY FONG 600 North Wolfe St, Baltimore, MD, 21287

Registrar

DHMH 17 Rev 1/2001

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MATTO 1540 **GLADYS** MARIE WALKER 2010 Medical 4a. Facility Name (if not institution, give street and n Examiner City, Town, or Location of Death 4c. County of Death Gieneral HOSOITAL Amore Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 Months Min. Hours Country) 1071371941 212-36-0594 68 Director VA Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral APT. 512 1701 EUTAW PLACE 21217 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. ò 1 Never Married 2 Married 1 Yes If Yes, Give 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates BLACK Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HEALTH PRACTICAL NURSE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) IRMA ELIZABETH LONG ည ARTHUR WILLIAM WALKER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

RAT.TTMORE. MD 21215 19a. Informant's Name/Relationship (Type, Print) 6965 GLEN HEIGHTS RD. BALTIMORE, MD GLORIA SMITH-GAINES/DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 Cremation 3 Removal from State 05-10-2010 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) ZION CEMETERY JAMES A. MORTON & SÓNS F.H., INC. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility BALTIMORE, MD 21217 1701-31 LAURENS ST. 23a. Par. . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury law requires that the death certificate be executed signed by the attending physician and defached for use as the burial-transi that initiated events resulting in death) Last Due to (of as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death Yes 2 No 9 Unknown 1 L Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 🗌 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? this certificate 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: 'within 24 hours after death.

To the Funeral Director: After this certifics 25. Was case referred to medical examiner?

1 2 Yes 2 No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 FR/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** erner 2010 May 03 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner izabeth rsing (enter imor If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Day, Year) 5. Social Security Number (In yrs. last birthday) **Funeral** 7. Age Days Hours Min. Months Director May 11,1932 Poland 220-30-2342 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, it. Medical Exp. infort. Intel by puffic d at once. 1 ☐ Yes 2 No **Funeral Director** MD Baltimore Arbutus 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21227 976 Regina Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Completed by Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade comp 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Accountant Accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unknown Josef Werner ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 976 Regina Drive, Arbutus MD 21227 Eleanor Werner-wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery May 7,2010 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Ambrose Funeral Home Inc. 1328 Sulphur Spring Road Arbutus MD 21227 23a Part1. Enter the disease or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final avicinson ew. **Physician** 5 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of) Box 68760, Physician/Medical To the Funeral Director: After this certificate has been signed by the attending t completely filled in by the funeral director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month 5 ☐ Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 3 Probably 4 ☐ Unknown 2 No 1 ☐ Yes Be Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performe death? 7m 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No WINGARY 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 04

Registrar
DHMH 17 Rev 1/2001

State

(g)

timore

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

20

32

Benson

egistrar's Signature

33

MD

31. Date filed Mort

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5 Physician/ Medical 4a. Facility Name (if not institution, give street and number, County of Deat Examiner Baltimure Nashington If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 Hours Maryland Director 216-48-8895 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Examiner must be notified at Director 1 Tes 2 No Glen Burnie Maryland Anne Arundel ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 201 Somerset Bay Drive Apt. 101 21061 U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 10 Black, White, etc. 1 ☐ Never Married 2 🕅 Married þ 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Completed 3 Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) N/A Homemaker Own Home Fled v 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be Marion Di11 Risper Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles A. Walsh, Sr. (Husband) 201 Somerset Bay Drive Apt. 101 Glen Burnie, Maryland 21061 20a. Method of Disposition
1 🔼 Burial 2 🗆 Cremation 3 🗀 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Hillcrest Memorial Cem. injury 05/11/2010 4 Donation 5 Other (Specify) Annapolis, Maryland 21. Signature of Funeral Service Licensee McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one causa on each line. Immediate Cause (Final Physician disease or condition resulting in death) Medical to (or as a consequence f): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be execute attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death 5 Other (specify) by the detached 9 Unknown Division of Vital Records, P.O. To the Funeral Director: After this certificate has been signed I completed filled in by the funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform 1 Yes 2 No 25. Was case ref_rred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 00 မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred Natural 5 Pending death. Accident
Suicide 2 🗆 No Investigation 24 hours after deat Funeral Director: 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Pertition Number Pranticion 1. The basis of my known does death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I only on witte of certif 29b. Signature ar 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of who completed cause of death (Item 23a) (Type, Print) trar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Unk M Medical acility Name (if not institution Town, or Location of Death **Examiner** 4c. County of Death KaHimore If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birt 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Min. Hours (Month, Qay, Country) Director Yrs or 28a-f show 10a. State 10b. County filed within 72 hours after death with the Maryland or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** BaHIMOTE 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? items 23a 2/205 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in 14. Race - American Indian. Armed Forces Black, White, etc. o 1 Yes 2 No If Yes, Give Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No "natural", Specify. 3 X Widowed 4 Divorced Year or Dates. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than College (1-4 or 5+) Mental Hygiene. aborer Be 17. Father's Name (First, Middle, Last ၉ lenti . Page 1 and 2 should tment of Health and N tant: If item 27 is ma Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Important: If it any injury or o once. Burial 2 Cremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service icensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the hode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Donaly disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Penyohra the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical signed by the attending d be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year 4 Pregnant at time of death 5 Other (specify) ☐ Yes _ _ ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown nis certificate has been si director, page 2 should l 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed After this certificate I 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one မ 4 Hursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 🗀 ER/Outpatient 3 🗌 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pending within 24 hours area To the Funeral Director: A 2 🗌 No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D314 MD 5/6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1+8+8+m1 . FYTAW ST finte 308 BALTIMORE 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 5,2010 1:05 pm HELEN ESTELLE WROCINSKI Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 1727 FLEET STREET BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Months Hours MA^{Menth}2^{Ov,}, ^Y°f^r919 MARYLAND 90 Director 219-01-0177 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at filed within 72 hours after death with the Maryland al Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A BALTIMORE 1 X Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Funeral 1727 FLEET STREET U.S.A. 21231 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. "natural". Specify: WHITE Completed 3 X Widowed 4 ☐ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natuany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) OWNER RETAIL STORE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FRANCIS MANTYK STELLA WOZNIAK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY SIEMEK/ DAUGHTER 5847 SLATE HILL PLACE, FREDERICK, MD 21704 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XX urial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST. STANISLAUS 5/7/10 BALTIMORE, MARYLAND Signature of Europa 18 LILLY & ZEILER INC. 1901 EASTERN AVENUE FUNERAL HOME BALTO., MD 21 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Or set and Jeath Immediate Cause (Final Physician/ enmon Medical resulting in death) Examiner Due to (or as Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknow þ signed t Part II. Other significant conditions $ilde{ heta}$ ontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ cate has been signage 2 should b 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforr Director: After this certificate I 1 Yes 2 No æ 25. Was case referred to medica 26. Place of Death (Check only one) examiner? ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Marther of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours af

To the Funeral Di

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Pragitioner: To the past of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of

State Registrar 30. Name and address of person who

31. Date filed (Month, Day, Year)

McDONALD

M.D

2801 HUDSON STREET, SUITE

21224

BALTIMORE, MD

ompleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2:10P M Clifton White Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Saint Joseph Medical Social Security Number 6 Sex 7. Age (In yrs. last birthday) if Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🗖 M 2 🗆 F Hours Min. Jan 1919 91 Mfssouri 494-09-1997 Director Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10a, State 10b. County Director Examiner must be notified MD Baltimore Towson 1 🗆 Yes 2 🗋 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21204 U.S.A. 1728 Ruxton Road items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 9 þ 1 Never Married 2 Married 1 X Yes If Yes, Give 2 No 1 ☐ Yes 2 ☐ No Specify: '41-'45 Specify: "natural" 3 X Widowed 4 Divorced White Completed Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired) during most of working Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Chemical Engineer 0i] permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Emma Muller ဂ္ White Clifton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1728 Ruxton Rd., Towson, MD 21204 Carol W. Ingalls-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State MD Vet, Garr. Forest 5/12/10 1 X Burial 2 Cremation 3 Removal from State Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William G. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Dau IM 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS disease or condition resulting in death) Due to (or as a consequence of): HYPOXIC RESPIRATORY FAILURE 10 DAYS Sequentially list conditions, Examine Dire to (or as a consequence or): if any, leading to in rediate cause. Enter Underlying sician and burial-transit Cause (Disease or iinjury that initiated events ACUTE RENAL FAILURE 10 DAYS Due to (or as a consequence of) resulting in death) Last Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death 2 No g Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PARKINSON'S DISEASE Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 X Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 **X** No မှ

Pnysician/ Medical Examiner

72 hours after death

Maryland 21215-0036

Baltimore,

P.O.

physician s the burial s certificate has the director, page 2 st director, funeral

Division of Vital Records, Hospital or Attending Physician: To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu

State Registrar 29b. Signature and title of certifier

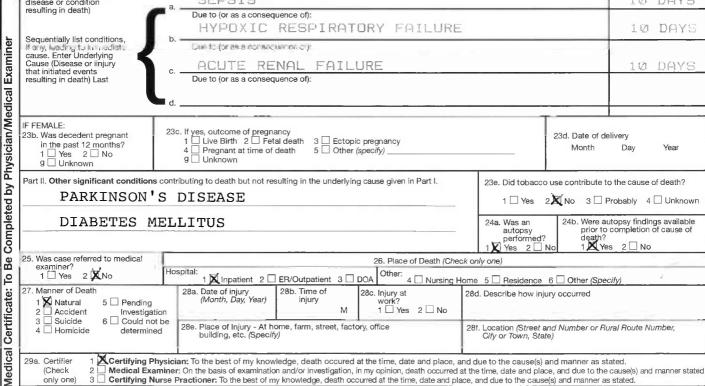
31. Date filed (Month, Day, Year)

MARTIN R LINKER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature



29c, License number

D39858

OSLER DRIVE TOWSON, MARYLAND 21204

29d. Date signed (Month, Day, Year)

2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20a-c, 22perFH, G903, 5/25/2010, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Sarah Louise Whited 30, 2010 9:22 April 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1324 Hampshire West Court #12 Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. Dec 3, 1965 9. Birthplace *(State or Foreign* Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months 1 M 2 X 44 227-13-0009 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1424 Hampshire West Court #12 20903 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married white If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify. Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) disabled none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard Hunter Nellie Schuyler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elmer Landuem/brother 329 Little Florida Rd; Poquoson, Virgina 23662 20a. Method of Disposition

1 ☐ Burial 2 A Cremation 3 ☐ Removal from State
4 ☐ Donation 5 Dectrify) 19 State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Metro Crematory, Inc. 5/21/2010 Baltimore, Maryland 21. Signalare of funeral Service Licensee

Ronal S. Wade, tor

22. Name and Address of Facility Cremation Society, of Maryland, State Anatomy Board, 655 W. Baltimore, Maryland, 21228

23a. Part, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cau e (Final disease or condition resulting in death) to (or as a consequence of): Due to for as a consequence of Due to (or as a consequence of)

Physician /Medical Examiner

permit. Pages Department of Important; If it any injury or or

- State Registrar

10a. State

MD

Director

Funeral

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Completed

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Physician

/Medical

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Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov ury or other traumatic event, the Medical Examinar must by notified at

Baltimore, Maryland 21215-0036

burial-transit and To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate. the attending physician ned for use as the buris as the signed by the a d be detached f cate has page 2 s

P.O. Box 68760

of Vital Records,

Division

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣ No 24a Was an autopsy performed? 1 🗆 Yes 2 🔼 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \textsty Residence 6 \subseteq Other (Specify) Hospital: 1 X Yes 2 ☐ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 St Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and ti 29d. Date signed (Month. Dav. Year)

State Registrar Name and address

31. Date filed (Month, Day, Year)

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After this

after death Director: A d in by the f

e Funeral Di

of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician. KADhnel 2010 MATHANIEL MAY Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Howard Columbia 12264 Green Meadow Dr., Apt. B If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 1 Year 8. Date of Birth 5. Social Security Number Age (In vrs. last birthday) Sex 1 M 2 □ F **Funeral** (Month, Day, Year) Days Months Hours Min. Country 057.12.6196 Feb 24, 1921 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 🗌 Yes 2 💢 No Columbia Howard 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Numbe Funeral 21045 U.S.A. 7070 Cradlerock Way apt. 201 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?,
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 'natural", or Š Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic. Aucons. 41-11-11 College (1-4 or 5+) Elementary/Seconday (0-12) Electric Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Nancy Carroll **Grover Cleveland Williams** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7156 Talisman Lane Columbia, MD 21045 Qiahna Swanston-Williams daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 07, 2010 Glen Burnie, MD Atlantic Crematory, LLC ervice Licens 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Onset and Death hediate Cause (Final Physician/ GODEN difease or condition Medical resulting in death) Due to (or as **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 f yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Day Year 1 Yes 2 L 9 Unknown sate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DYSPLASTIC SYN MONE 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other (Specify Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury 28b. Time of Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: Natural (Month, Day, Year) injury 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check

State Registrar

only one) 29b. Signature and the of o

PARENCET PARENT, Columbs, Me 2/0/4

Due D

EVENE, MO 11055 Little 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician Month 1131AM 2010 Yusko 8 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Rosedale FRANKLIN Square Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 □ F 49 Director 220-72-6988 Maryland September 17,1960 Usual Residence of Decedent 10a. State 10h. County 10c, City, Town or Location 10d. Inside City Limits 'natural", or items 23a or 28a-f show dieal Examinar must be notified at Baltimore Overlea 1 ☐ Yes 2 No Director Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? **USA** 311 Willow Avenue 21206 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 White ģ 1 ☐ Yes 2 ☐XNo Specify 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. Baltimore County Schools Bus Driver 11 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked Marlene Ouattro Thomas Yusko ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once. 3001 Scotch Court, Abingdon, Maryland ex-wife Theresa Camponeschi 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition May Tie 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 2010 Bayview Crematory 21. Signature of Funeral Service Licenses ^{22. Name and Address of Facility}
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, Md. 23a. Part 1/ Errier the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Lause (Final disease or condition resulting in death) **Physician** Sepsis

Due to (r as a consequence of): /Medical Examiner Lymphoma Due (or as consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached for 1 □ Ves 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has I rector, page 2 s autopsy performed' 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1⊠Yes 2□No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 Inpatient 2 ER/Outpatient 3 DOA this eral Director: After th filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated.

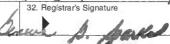
State

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Franklin

RES 0000

Square Hospital DR Balto md 21237

29d. Date signed (Month, Day, Year) 5/8/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🚄 🕕 📗 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician May 20°1°0 8:05 А.м George Paul Zaranski /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 107 Longridge Court Timonium 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2 - 27 - 1936 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 217-32-9366 Director 74 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, it is I wideal Everying must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore City Md. N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224-3708 2608 Foster Avenue U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A Electrician Electrical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Zaranski Bertha Kudlack ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Florence Walsh- Sister <u>107 Longridge Court Timonium, MD 21073</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 5-7-2010 Baltimore, MD 22. Name and Address of Facilit Kaczorowski Funeral Home, P.A. Funeral Service 1 Dundalk Avenue Baltimore, rt 1. Enter the disease ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic fancela /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Exami physician and the burial-trans Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 robably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? yes 2 ☑No diabetes 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Sister's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation nours after death.

neral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D066049 May 7, 2010

Hospital

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr.Richard Schraeder, Jr., M.D. 7501 Osler Drive, Ste.102 Towson, Md21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 24a State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MAY **ESTELLE** 2010 ZEMIL 06 07:00A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SUNRISE ASSISTED LIVING PIKESVILLE BALTIMORE Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 🗓 F Months Hours Min 216-66-6111 0670871915 **Director** 94 Yrs Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Yes 2 X No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2208 SUGARCONE ROAD 21209 USA 12. Was Decedent Ever in U.S. Armed Forces?.

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", 3 X Widowed 4 Divorced Specify: Year or Dates WHITE permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life, DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) **TEACHER EDUCATION** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ HARRY GROSS EVELYN BRAFFMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2208 SUGARCONE ROAD, BALTIMORE, MD 21209 JACK ZEMIL / SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) HEBREW YOUNG MEN 05/09/2010 WOODLAWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Tenel failing disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner hapertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗀 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Other (specify) Tyes 2 □ No ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by be det 23e. Did tobacco use contribute to the cause of death? Š Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\sum \) No Other: 4 \square Nursing Home 5 \square Residence 6 \bowtie Other (Specify) Certificate: To ER/Outpatient 3 DOA 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending work?
1 Yes 2 No s after death.

I Director: A
d in by the fu Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined within 24 hours at To the Funeral D completed filled in Medical 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Gartifying Nurse Franticeer To the best of my knowledge, death occur d at the time data and place, and due to the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Ruhard C Scra, aD 0 0020604 5/6/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, D

Richard A. Serz, 40; Svyle 450; 10755 Fells Rd., Lutherville, 4d 21093

20 082. Re grar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ 15 PM 3Ő 2010 <u> Augusta Durant Arthur</u> Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** N/ABaltimore Overlea Mariner Nursing Center 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. 1 🖾 M 2 🗆 F Months Hours South Carolina 1928 Director 250-48-5941 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Xes 2 No Baltimore MD 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? by Funeral 4001 Pinewood Avenue 21206 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Housing 6th grade <u> Maintenance Worker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lucille Absom Emmet D. Arthur 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mae Frances Williams/Daughter 4001 Pinewood Avenue Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/10/10 Greenmount Cemetery Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Road Baltimore, Maryland 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cau on each line Interval Retween Onset and Death Immediate Cause (Final ARMIOVAS CULAR HAROSCLEROTIC Physiciani disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence or): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year 4 Pregnant a 9 Unknown Pregnant at time of death 1 Yes 2 No ed by the a detached f s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an is certificate has be director, page 2 s autopsy performed death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide 5 Pending work? 1 Yes 2 No Director: A Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Vithin 24 hours are
To the Funeral Dir Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number MAY D0060560 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RD # 208, BALTIMORE, MD KHETERRAL 9106, PHILADELPHIA 31. Date filed (Month, Day, Year) State 12 Registrar

DHMH 17 Rev 7/2009

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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Martla Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show min portant: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fur	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Was Decedent Ever Armed Forces? □ Yes 2 ☑ No If Yes, Give Year or Dates.	If Yes, sp	ecify Cuba	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- o Rican, etc.)		14. Race - Ame Black, White Specify:		
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. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death is within 25 hours after death. To the Luneral Director, After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but		IF FFMA! F:	ic. If yes, outcome of p 1 Live Birth 2 4 Pregnant at tin g Unknown	Fetal dea			ey			23d. Date of del Month	livery Day Year
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	Hospi 24 hou Funer eted fill	edica		r: On the basis of exam	nination and	or investigation, in	n my opinia	on, death occurred	at the time, date a	and place,	and due to the	cause(s) and manner stated.
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	100		30. Name and address of person who con	npleted cause of death	h (Item 23a)	(Type, Print)	CTPF	FT RA	71 - 20	= M	0 212	47/
	Stat		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	h hans	Les !	- · > WIL	IMORE	- >		- 1
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Desement's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12:02 PM ΜÄΣ 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BACTIMORECITY NO50 OF BACTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months 65 Director Usual Residence of Deceden 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If fire 27 is anaked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County Director 1 Yes 2 □ No timore 10e. Street and Numbe 10g. Citizen of What Country? Funera 21216 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces' þ 1 Never Married 2 Married ☐ Yes Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life, DOMPT use retired) (Specify only highest grade completed) nday (0-12) College (1-4 or 5+) Be or Rural Route Number, City or Town, State, Zip Code, atonsviller Baltimore, 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerar Service Licer 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Physician/ 5 day disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of ed by the attending physician and detached for use as the burial-transit that initiated events Due to (or as a consequence of). resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown been signature Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 s autopsy performed 1 Yes 2 4No Be Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Thpatient 2 🗆 ဂ္ ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work' 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) 0 MOSPITAL OF BALTIMORE 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Vear Month **Physician** Frances Mav 11 2010 6:55 Α /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Edenwald Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day, eb. 3, 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🕱 F England 214-18-5901 88 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-f show other treumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Baltimore Towson 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or Items 23e or U.S.A. 800 Southerly Avenue 21286 Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status □Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White þ If Yes, Give Year or Dates: 3 ₩ Widowed 4 Divorced "neturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Importent: If tem 27 is marked other then "ne eny injury or other treumetic even" (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Social Security Admin. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Footit Ina Allan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Giangrandi/son-in-law 814 Boyce Avenue, Towson, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □XBurial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Parkwood Cemetery May 14,2010 Parkville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final dementia **Physician** End Stage disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury Examiner Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 210 No this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient Medicai Certification; To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident Hospitel or Attending 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 | Homicide within 24 hours To the Funerel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Schen CRNP R154032 5/11/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Susar

31. Date filed (Month, Day, Year)

0106

2. Registrar's Signature

800 Southerly Rel Toward, MD

CRNP

Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate be executed

Death this certificate has been signed by the attending physician a director, page 2 should be detached for use as the burial -23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA Other₄ Nursing Home 5 Residence 6 Other: 1 Yes 2 No 28a. Date of Injury FOUND: After 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Natural Subject shot FOUND: 5 Pending illed in by the f 1 Yes 2 V No within 24 hours after death 2 May 4, 2010 2316 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be or Town, State) 2100 Frederick Avenue, Baltimore, Md. determined (Specify) Sidewalk 4 V Homicide To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 5, 2010

2121

State Registrar 30. Name and address of person who completed cause of death (Item 23a)

Carol Allan, MD

31. Date filed (Month, Day

Deav

egistrar's Signature

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2010 Jeanette Irene Bowers /Medical 4a. Facility Name (If not institution, give street and number Jown, or Location of Death 4c. County of Death Examiner Sedale 0 Year If Under 24 Hrs. If Under 1 Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🛛 F Director 86 212-22-5661 01/26/1924 West Virginia Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23a or 28a-f show the Medical Examination and be notified at 1 ☐ Yes 2X No Director Baltimore Essex 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 607 Virginia Avenue 21221 Funeral U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Men al Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examples Once. Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🛛 No ≥ Specify: 3 XWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Baltimore City 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Houston D. Carpenter <u>Unknown</u> Cross 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara A. Hinkelman (daughter) 4209 Manor Woods Drive - Glen Arm, Maryland 21057

Method of Disposition Date | 20c. Location - City or Town, State altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gdns. 05/12/2010 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 0 disease or condition resulting in death) /Medical Due to (or as a consequence of): conjective heart failure) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tranresulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Month Ye ar 5 ☐ Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the lirector, page 2 st autopsy performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 5 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this : After this stuneral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 No I Director: / 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated within 2 To the I 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 20067697 5-10-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 404 Eastern Blud, ESSAY, MD 21221 elia Sanchez 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryland / Department		and Mental Hyg	iene
	42		Registrar 1. Decedent's Name (First, Middle, Last)		tificate of Death	2. Date of Death	eg. No. 3. Time of Death
	Physici /Medio		Almeda	Br	rown	May	6 2010 12:57 P.M
	Examir		4a. Facility Name (If not institution, give s The Johns Hopkins Ho	spital	4b. City, Town, or Location of Baltimore City		4c. County of Death
	Funeral Director		5. Social Security Number 6. Sex 1	M 2 XF 7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year If Under Months Days Hours	24 Hrs. 8. Date of Birth Min. Month, Day,	Year) 3. 1916 Georala
			Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	peation	11.1009 15	10d. Inside City Limits
	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Director	10e. Street and Number	Balt	10f. Zip-Code	10	1 X Yes 2 □ No
	th with 23a or st be n		2617 Garre	H AVE.	21218		USA
_	items items ner mu	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican	gin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036	ours afrail, or	δ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: Black
15-0	in 72 h "natur edical	Completed	15. Decedent's Educ (Specify only highest grade	completed) (Give	dent's Usual Occupation kind of work done during mos DO NOT use retired)	t of working	16b. Kind of Business/Industry
212	ed within /giene. er than "	Com	Elementary/Secondary (0-12)	College (1-4 or 5+)	aborer		Packing House
and	d be file ental Hy red oth event	Be	17. Father's Name (First, Middle, Last)	Watson	18. Mothe	er's Name (First, Middle, M	Maiden Surname)
Maryland	2 should and Mer is marke aumatic	욘	19a. Informant's Name/Relationship (Typ	e. Print) Granddaugh to 196. Maili	ng Address (Street and Numb	er or Rural Route Number,	City or Town State, Zip Code)
	1 and 2 Health em 27 ther tra		MS. Theresa 20a. Method of Disposition	Collins 6	435 N 16T	St. Phi	ade phia Pa.
mor	Pages nent of nt: If Ite		1 N Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)			5/12/2010 -	Balto Md
Baltimore	permit. Pages Department o Important: If I any injury or once.		21. Signature of Funeral Service Licenses	14	Name and Address of Pacility	Stuneral	Home P.A
	40 = a 0		23a. Part 1. Enter the disease, or complic	eations that clused the death. Do not ent	222 W. North ter the mode of dying, such as	Ave. Bar-	est, Approximate Interval Between
	Physician		shock, or heart failure. List only one Immediate Cause (Final disease or condition	CARDIAC CE	LL ISCHER	MIA	Onset and Death
7	/Medical Examiner		resulting in death)	Due to (or as a consequence of):			
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):	1010		
٥.	executed n and rial-transit	Examiner	Cause (Disease or injury that initiated events cresulting in death) Last	Due to (or as a consequence of):			
,092	cate be executed oblysician and the burial-transit	dical	d				
89	,0 - 01		IF FEMALE:	Bc. If yes, outcome of pregnancy			23d. Date of delivery
Box	death e atter ed for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)		Month Day Year
P.O.	hat the d by th detach		9 ☐ Unknown Part II. Other significant conditions con	tributing to death but not resulting in the i	underlying cause given in Part	I. 23e. Did tob	pacco use contribute to the cause of death?
rds,	v requires that the death been signed by the atter should be detached for	ed by	ARRYTHMIF	+		1 Yes	s 2 Mo 3 ☐ Probably 4 ☐ Unknown
of Vital Records,	N S S	Completed		·		24a. Was an autopsy perform	prior to completion of cause of death?
Ita		0	25. Was case referred to medical		26. Place	1 ☐ Yes 2 of Death (Check only one	2 (12√No 1 □ Yes 2 □ No)
of <	ling Physician: After this certifications funeral director,	To B	examiner? 1 Ves 2 No 27. Manner of Death	ospital: 1 Inpatient 2 FR/Outpatier 28a. Date of Injury 28b. Time of		rsing Home 5 Resider	
ion	nding F tth. : After t e funer	ation	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	f 28c. Injury at Work? M 1 ☐ Yes 2 ☐ I	28d. Describe ho	w injury occurred
Division	Il or Attending Physician: after death. Director: After this certifica d in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Str City or Town,	reet and Number or Rural Route Number, State)
	Hospita 4 hours Funeral tely fille	edical C		ician: To the best of my knowledge, deather: On the basis of examination and/or in and manner stated.			
	To the within 2 To the comple	Me	29b. Signature and title of certifier		29c. License number		d. Date signed (Month, Day, Year)
			1 /m	- mo mort	D0068	\$706	MAY 06,2010
_	\		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type,		600 North Wolf	fe St, Baltimore, MD, 21287
	Sta Registr		31. Date filed (Month, Day, Year) MAY 12 20	32. Fi gistrar's Signature	harles		

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	•	1 - State of Maryland / Department Certificat	e of Death	Reg. No. 2 1 1 1 1 7 1 2
Physic /Medi		1. Decedent's Name (First, Middle, Last) ANGECA BAZE	Ma	-9 / -1 / //
Examin Funeral Director	ner	Northwest Ba	Town, or Location of Death altimore Tyear ff Under 24 Hrs. 8. Date Mont	of Birth th, Day, Year) N/A State or Foreign Country) Maryland
Maryland f show	tor	Usual Residence of Decedent	imana	10d. Inside City Limits 1 ⊠ Yes 2 □ No
th with the A 23a or 28a-	Funeral Director	10e. Street and Number 10f. Zip	timore Code 21216	10g. Citizen of What Country? U • S • A •
5-UU36 72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Evernine must be notified at	by	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Sive 1 Yes, Give 1 Yes, Give 1 Yes, Give 1 Yes on Dates: 13. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Yes, Spe	dent of Hispanic Origin? (Specify Yes cify Cuban, Mexican, Puerto Rican, etc. 2 No Specify:	or No- c.) 14. Race - American Indian, Black, White, etc. Specify: Black
IOTE, Maryland 21215-UU36 ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinations and the nutitied at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade 16a. Decedent's Usu (Give kind of we life. DO NOT u	rk done during most of working se retired)	16b. Kind of Business/Industry Diamond Cab
Maryland Z nd 2 should be filed v lith and Mental Hygic Z7 is marked other r traumatic event, It	To Be Co	17. Father's Name (First, Middle, Last) Herbert Baze	18. Mother's Name (First, M Shirley	
e, Maryla t and 2 should Health and Mer m 27 is marke ther traumatic		Crystal Baze(daughter) 3251 Gu	lfport Dr.,Balt	Number, City or Town, State, Zip Code) Limore, MD 21225 20c. Location - City or Town, State
tir trer rtmer rtant:		1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) And Cremator		Baltimore,MD
Dermi permi Depa Impo		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mos shock, or heart failure. List only one cause on each line.	nth dripes of Facility own Jr. Brown Jr. N. Fulton Ave. de of dying, such as cardiac or respirat	
Physician /Medical Examiner		Due to (or as a consequence of):	mco	
68 / 60, tificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Extra Underflying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		
box of gath certif attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic 4 Pregnant at time of death 5 Other (s		23d. Date of delivery Month Day Year
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	Certification: To Be	2 ☐ Accident investigation M		100mm
UIVISION Hospital or Attending 44 hours after death. Funeral Director: After		3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factor building, etc. (Specify) 29a. Certifier 150 Certifying Physician: To the best of my knowledge, death occurred		ation (Street and Number or Rural Route Number, or Town, State)
To the Hosi within 24 ho To the Func	Medical	(Check only one) all Medical Examiner: On the basis of examination and/or investigation and manner stated.		
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	D158/2	Man 7 2010
St. Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	on Blud So	ujat or ajuoj

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 8:15 am 2010 Shirley Frances Bowman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Arnold Futurecare If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours 1 □ M 2 🕻 F West Virginia 4, 1934 233-50-3608 Dec. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the fredient Exp. in er must be notified at 1X Yes 2 □ No Director Maryland | Prince George's Bowie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20715 3603 Majestic Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Kmart Receiving Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Hazel Crabtree Holland Patterson Sanders မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 208 Rebecca Ann Court Millersville, MD 21108 permit. Pages 1 and 3 Department of Heath Important: If item 27 any injury or other tra once. Diane Arthur/ Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Nourial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 5/14/2010 | Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 20715 Sh 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician minuted Muccardial disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed the attending physician and the burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day in the past 12 mor 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 I Unknown 9 Unknown is been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed page 2 1 ☐ Yes 2 ☐ No 2 🗓 1 □ Yes 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) examiner? Other: 4 Daysing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner 1 eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 tural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident To the Hospital or Attenct within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 50725 MD

State Registrar knnite

31. Date filed (Month, Day, Year)

rans Hwy M. Worsville MD 21108

30. Name and address of persop who completed cause of death (Item 23a) (Type, Print)

32

Registrar's Signatu

a

Please Type or Print in Black Indelible Ink, Fraure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last)
Joseph J. Bushel
Joseph J. Bushel 2 Date of Death 3. Time of Death Day **Physician** 2010 11:35p M May 8 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) MD Months Days Hours 10-03-1928 1 ☑ M 2 ☐ F 217-24-5410 81 **Director** Usual Residence of Decedent 10b. County 10a. State 10c. City Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Mudical Examiner must be notified at Director MD Baltimore 1X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Funeral 5909 Theodore Ave 21214 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X es 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Data Processor Computers Department of Health and Mental Hygic Important: If Item 27 is marked other i any injury or other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Joseph J. Dushel Virginia Bean ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Marucci (Daughter) 4218 Graceton Rd Pylesville, MD 21132 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens Of Faith Cem. 05-15-2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner C. difficult colitis Sequentially list conditions, if any least Underlying cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Physician: The law requires that the death certificate be use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ō in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate | performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ZINO 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∭ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director; filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Cynthia Smano 10 00051347 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. CHOVILIST BUITMORE MD 2120 10 SOFIAMO MO enthia 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 12 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 930 AM Annie Mildred Brown Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Havre De Grore Hartord Jens 157L If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 👿 F Days Hours Min. Country) NC 93 08[™]677.-^D1′9[°]16 212-24-8643 Director Usual Residence of Decedent ı "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director Harford MD Joppa 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 706 Old Joppa Rd 21085 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates ed other than "natu event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Tools Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) marked o ည t. Page 1 and 2 should be f tment of Health and Menta tant: If item 27 is marked jury or other traumatic e Lossie Proctor Joshua Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $706\ 01d\ Joppa\ Rd\ Joppa,\ MD\ 21085$ Jane Davis 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 05-13-2010 Parkville, MD Parkwood Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examine Sequentially list conditions, Examine il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of: signed by the attending physician and deedeched for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 Yes 2 Dunknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by director, page 2 should be Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown peen Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy death? 1 Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, p Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Division of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6
Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) fiolie MO 032 Which 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) St 40G ND 21078 Kammalu Munacustr (10%. 31. Date filed (Month, Day, Year) State Registrar

Amend #1, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene / | | | Certificate of Death 1. Decedent's Name (First, Middle, Last) Johnny James Battle, Jr. 2. Date of Death 3. Time of Death Physician/ 48PM 2010 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 7. Age (In yrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Ye 532-50-6999 1 XM 2 F 61 Months Hours Min. Florida Director 1948 Nov. Usual Residence of Decedent 23a or 28a-f show 10b. County er than "natural", or items 23a or 28a-f sho , the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Bel Air Harford 1 Tes 2 No Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21014 Funeral 1420 Hardley Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 XYes 2 No
If Yes, Give Black, White, etc. δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

Procurement Manager Elementary/Seconday (0-12) College (1-4 or 5+) Construction permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Johnny James Battle, Sr. Helen Louise Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 1420 Hardley Court, Bel Air, Maryland 21014 Jasmine Battle / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Towson, Maryland Hilltop Service Corp. 5-11-10 4 Donation 5 Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland, 21009 1. Enter the diseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest in tik, or heart failure. List only one cause on each line. Onset and Death Imma liate Cause (Final Physician/ FUNGEN disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that the death certificate be executed physician and the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Yes 2 No g Unknown 9 Unknown is been signed by the 2 should be detachε Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 Jas this certificate 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Hospital Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) 2 No 1 🗌 Yes ပ 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes Certificate: 28d. Describe how injury occurred Natural 5 Pending injury ☐ Accident 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature icense number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AST 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5/10/2010 3:00 PM Jean M. Boyd Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Brinton Woods Nursing Home Sykesville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Hours 8/8/1930 Director 577-44-1282 79 VA Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Gaithersburg Montgomery 10e. Street and Numbe 10g. Citizen of What Country? Funeral 20877 USA 568 Russell Ave. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🖾 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: White "natural", 3 XWidowed 4 ☐ Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Mediconce. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Instructor & Administrator Anne Arundel Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Estelle Ames Eugene Moodispaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1401 Buckhorn Rd., Sykesville, MD 21784 Anne Frampton/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ebenezer UMC Cemetery 5/18/2010 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Euneral ²Burrier Oue Enlity Funeral Home & Crematory, 21784 1212 W. Old Liberty Rd., Winfield, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Month Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death signed by the a d be detached for Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy death? performed? 1 🗌 Yes 2 🗆 No 2 3 No Yes 25. Was case referred to predical Be 26. Place of Death (Check only one) examiner? 2 🛂 No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

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State Registrar

only one 29b. Signature and title of certifie

HTRICK

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

URNES

32. Registrer's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 May :55AM M Marian Estelle Bronson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ${ t Montgomery}$ Rockville Nursing Home <u>Rockville</u> 9. Birthplace (State or Foreign Country) New Jersey 8. Date of Birth (Month, Day, Age (In yrs. last birthday) **Funeral** Days Months 1 □ M 2 🛛 F Hours 93 Director February 6, 142-01-7459 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 22 minury or other traumatic event, the Marianal injury or other traumatic event, the Marianal injury or other traumatic event. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Tes 2 X No Derwood Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 18625 Azalea Drive <u> 20855</u> United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Secretary Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Stella Clayton Arthur Raymond Grove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18625 Azalea Drive Derwood, Maryland 20855 Susan Bronson Rogers/ Daughter 20b. Place of Disposition (Name of Date Montgomery Crematorium Inc. 1 Burial 2 X Cremation 3 Removal from State Bethesda, Maryland Pumphrey Funeral Home/ t Montgomery Avenue 50-2805 4 ☐ Donation 5 ☐ Other (Specify) 2010 10 22. Name and Address of Facility Robert A. Pu Rockville, Inc. 300 West M Rockville, Maryland 20850-21. Signature of Funeral Service Licensee M00335 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ Cancer of Lung with Metastasis disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) Pneumonia Sequentially list conditions, if any, less ling to immediate cause. Enter Underlying Examine Due to or as a consequence of Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed Respiratory Insufficiency attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 F FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) B B Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 1 Tes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA ရှ 27. Manner of Death 1 💆 Natural 28a. Date of injury 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Certificate: injury (Month, Day, Year) 5 - Pending 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) voinwo D47330 May 7, 2010

State Registrar Thomas V.

31. Date filed (Month, Day, Year)

Edmonston Drive #207, Rockville, Maryland 20852

50 West

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Re

Joseph,

			Amedn #1 & 29c,	Type or Pringer MD G	nt in Bla 903 5/ aryland	ack In 12/10 / Depa	delil TT rtme	ole Ink	. Ens ı ealth a	ure A	II Copie Iental Hy	s Are	Legi	ible.		700
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	Medic Examin		4a. Facility Name (if not institution, give s		ک ده ۱			, Town, or			19	40	c. County	-		
	Funeral		5. Social Security Number 6. Sec	Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month Day Year)								9. Birthplace (State or Foreign Country)			or Foreign	
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Maryland 21215-0036	ırs after deat ural", or iten I Examiner r	ρ	1 Never Married 2 Married 1 Yes 2 No												ean Indian, etc.	
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V	Physician/		shock, or heart failure List only on Immediate Cause (Final disease or condition			ison	en	a							Interval Be Onset and	Death
Samo	Medical Examiner		resulting in death)	a. Due to (or as a											4 10	, (
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P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the bur		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 Pregnant at 9 Unknown	2 🗌 Fetal de	eath 3 🗌 h 5 🗍	Ectopic Other (s	ictopic pregnancy tther (specify)					23d. Dat Mor		-	Year
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	n 24 ho	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examir only one) 3 Certifying Nurse	ner: On the basis of ex	amination and	d/or investi	gation, ir	n my opinior	n, death occ	curred at	the time, date	and place	e, and due	to the ca	use(s) and m	anner stated.
	To the within comp.		29b. Signature and title of certifier				29	c. License	number P		7	29d. Da	ate signed	(Month,	Day, Year)	
	lot		30. Name and address of person who co		eath (Item 23a	a) (Type, Pr	int)	hlo	7.0.10	Cito	eet Ba	/4.	ne v	u k =	2/20/	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ BERRY 2010 EARL MAY G G 05:30AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death GENESIS RANDALLSTOWN CENTER BALTIMORE RANDALLSTOWN If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 07 08 Year) 30 Months Min. 1 ★ M 2 □ F Hours Director 79 MD 220-20-3470 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at ould be filed within 72 hours after death with the Maryland ind Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Pikesville 1 Yes 2 XNo MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21208 U.S.A. 9228 James Howard Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14, Race - American Indian, Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify. Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) 2th grade Steel Worker Beth Steel Corp. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic <u>Maggie Dillard</u> Harry Berry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21208 19a. Informant's Name/Relationship (Type, Print) 9228 James Howard Lane, Pikesville, Erlene Wilson-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/14/2010 Cedar Hill Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sediate Cause (Final 21215 Baltimore, Approximate Interval Between Immediate Cause (Final Onset and Death Cancer Lung Physician, disease or condition resulting in death) 1 year Medical Due to (or as a nsequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of: To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by disease renal 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0058965 2010 1801 WENTWORTH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAIMA KHAWAJA BALTIMORE 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2010 T-2-7P M Betty Lou Bunker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner County of Death BURNIE GIEN **JUNDE** BACHINGTON MEDILACT ENTER If Under 1 Year If Under 24 Hrs. Funeral Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign MD (Duntry) 1 □ M 2 🔽 F Hours 0671571945 212-44-9494 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21060 7864 Cheverly Lane USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. þ 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give 1 Yes 2XXNo Specify 3 Widowed 4 Divorced Specify: White Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) n/a n/a permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mazy Rumley Earnest Byrd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7864 Cheverly Lane Glen Burnie, MD 21060 Richard Bunker / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State Ardent Crematory 5/7/2010 Hanover, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ardent Cremation Service . Signature of Fyneral Service Licensee 7522 Connelley Drive #N Hanover, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence ultisician and burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? 1 Yes 2 9 Unknown 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed

1 Yes 2 this certificate filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completed filled in by the funeral Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 and address of person who completed cause of death (Item 23a) (Type, Print) 1 ABA 50 i 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Physician/ 2010 May 7:30 PM Thomas Wayne Bland Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Montgomery Hospice - Casey House Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) Florida 1 🖾 M 2 🗆 F Hours 05/24/1957 Director 213-76-2126 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nothers" any injury or other transitions. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Montgomery Olney 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral U.S.A. 20832 3617 Sundown Farms Way Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc à 1 Never Married 2 Married ☐ Yes 2 🗓 No 1 Yes 2 X No Specify: If Yes, Give Specify: Completed 3 Widowed 4 X Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Commercial Electrician Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Bland Robert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Newbury Rd, Gaithersburg, MD 20882 Debbie Yarrington / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 05/10/2010 Hanover, Maryland Anatomy Gifts Registry 4 X Donation 5 Other (Specify) 21. Signature of Fureral Service License 22. Name and Address of Facility Anatomy Gifts Registry MD 21076 7522 Connelley Dr., Ste. P, Hanover, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ Pancreatic Cancer disease or condition Medical resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Other (specify) Pregnant at time of death 9 Unknown ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by þ 2 No 3 Probably 4 V Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy nas 2 🔀 No certificate 1 Yes 2 No Yes 25. Was case referred to medica 26. Place of Death (Check only one) 8 Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSpice 1 🗌 Yes 2 X No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes Certificate: 28d. Describe how injury occurred within 24 hours after tream.

To the Funeral Director: After 1 injury 1 X Natural 5 Pending Accident 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP, 6001 Muncaster Mill Rd, Rockville, MD 20855 Nicole Christenson, 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

	Amend Pi line For Amend Item	b, 25, per ME G 23a Fere per Marylang	ack Indelible Ink. Ens 903 5/25/10 TT 904-906/10/2010 The Certificate of Death	and Mental Hy	giene	
	Registrar		Certificate of Death		Reg. No.	lu/
Physician/	1. Decedent's Name (First, Middle, L	ast)		2. Date of De Month	Day Year	3. Time of Death
Medical		mn		May		3:00 P
Examiner	4a. Facility Name (if not institution, gi	ve street and number).	4b. City, Town, or Location of	of Death	4c. County of Dea	ith
Funeral		Sex 1. Age (In yrs. last	birthday) If Under 1 Year If Under	24 Hrs. 8. Date of Bi	rth 9. Bi	rthplace (State or Fore
Director	214-28-0759	1 DM 2 DF 76	Yrs. Months Days Hours	Min. (Month, Da		ountry) VA
wo	Usual Residence of Decedent					
ylanc ed at	10a. State 10b. County	10c. City, I	own or Location			10d. Inside City Lim
or 28a-f sho notified at Director	10e, Street and Number	109	1 hmore		40 000 000	
ith th		a avenue	A1215		10g. Citizen of What C	oundy?
be filed within 72 hours after death with the Maryland ental Hyglene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	3810 Sequoto	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Original If Yes, specify Cuban Mexican	gin? (Specify Yes or No		erican Indian.
ter de amine smine	1 Never Married 2 Married			, Puerto Rican, etc.)	Black, Whi	
irs affural",	3 Divorced	If Yes, Give Year or Dates.	1 ☐ Yes 2 ☑ No Specify:		Specify:B10	ick
vithin 72 hours at iene. r than "natural" the Medical Exa	15. Decedent's (Specify only highest		16a. Decedent's Usual Occupation (Give kind of work done during most	of working	16b. Kind of Business	Industry
thin 7 than than 2 com	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DO NOT use retired)		Church	2/
Hygiene. other tha ent, the A	17. Father's Name (First, Middle, Las	<u> </u>	//)inister	er's Name (First, Middle	Maiden Surname)	Ch.
2 should be filed th and Mental Hy 27 is marked ott traumatic even	Landon S.	ni th	Bol		00025	
1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	19a. Informant's Name/Relationship	(Type(Print)	19b. Mailing Address (Street and Number			ip Code)
and 2 sh Health a tem 27 is	Izell Crumo	1 Husband	A 5 O	Tvenue T	D 1/.	1) 21215
of Heal of Heal fitem ;	20a. Method of Disposition		e of Disposition (Name of petery, crematory or other plage)	Date	20c. Location - City o	
Page 1 ament of hant of hant If ite	1 We Burial 2 Cremation 3 4 Donation 5 Other (Spe	- Herioval Iloni State		5-15-2010	Ba 140.	MD
permit. Page Department Important: I any injury o once.	21. Signature of Funeral Service Lice	insee //	22. Name and Asses of Facilit			reral Serv
8 8 E E 6	Vancher C	There	8728 Liberty	Rd Randa	1/stown, m	D A1133
	23a. Part 1. Enter the disease, or co shock, or heart failure. List only		Do not enter the mode of dying, such as	cardiac or respiratory a	rrest,	Approximate Interval Between
Physician/	Immediate Cause (Final disease or condition	= Subarach nuic	l hemorrhage			Onset and Deat
Medical Examiner	resulting in death)	Due to (or as a consequen	ce of):			
	Sequentially list conditions,	b. Hypertension				
kecuted and al-transit	cause. Enter Underlying Cause (Disease or liniury	Directo (or as e nonsequen	Co .tl	1//	AL EXAMINER	
executed an and irial-transii	that initiated events resulting in death) Last	c. Due to (or as a consequen	ce of):	SPROVED BY MEDI	AL EXAMINE	
= 2: g 6		d	ce of): CERTIFICATI	7.6		
icate p physis the		u	/			
ician: The law requires that the death certificate be e certificate has been signed by the attending physicial rector, page 2 should be detached for use as the bunined or an active bunined or an active bunined to a should be detached for use as the bunined and active and active active and active active and active active and active activ	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of d	elivery
e atte	in the past 12 months? 1 Yes 2 X No	4 Pregnant at time of dea	th 5 Other (specify)		Month	Day Year
by the tache	g 🗌 Unknown					
s that gned be de	Part II. Other significant conditions	contributing to death but not resulti	ng in the underlying cause given in Part		tobacco use contribute t	
equire				1	Yes 2 No 3 I	
The law requires cate has been signage 2 should to Completed				24a. Was	opsy prior to	utopsy findings availa completion of cause
The I					ormed? death? 2 🔀 No 1 ☐ Ye	es 2 🗓 No
cian; sertific ector,	25. Was case referred to medical examiner?	Hospital:	26. Place of Dea	th (Check only one)		
Physical this call direction and direction and the call direction an	1♣ Yes 2 No 27. Manner of Death	1 X Inpatient 2 □ ER	VOutpatient 3 DOA Other, 4 No Bb. Time of 28c. Injury at		idence 6 Other (Spe	cify)
tal or Attending Physician: The law requires that the death certificate but after death. Is after death. In Director. After this certificate has been signed by the attending physiced in by the funeral director, page 2 should be detached for use as the but the funeral director. Certificate: To Be Completed by Physician/Medic	1 Natural 5 Pending	(Month, Day, Year)	injury M 1 Yes 2	1	how injury occurred	
or Attending P after death. Director: After t in by the funera Certificate:	2 Accident Investigat 3 Suicide 6 Could no	be 28e. Place of Injury - At home			Street and Number or R	ural Route Number,
affer affer din b	4 — Hornicide determine	building, etc. (Specify)			wn, State)	
ne Hospital or Attending Physician; The law requires that the death certificate be in 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physicipleted filled in by the funeral director, page 2 should be detached for use as the but the funeral director, page 2 should be detached for use as the but we dical Certificate: To Be Completed by Physician/Medical	29a. Certifier 1 A. Certifying Pl	nysician: To the best of my knowled	ge, death occured at the time, date and	place, and due to the c	ause(s) and manner as s	tated.
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director, Medical Certificate: To Be (nd/or investigation, in my opinion, death or nowledge, death occurred at the time, date			
Voriginal Community	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mon	
	James (anno MD	0006312	9	May 7,	2010
12	30. Name and address of person wh				,	
\0 \	JAMES E CONNAY	MD SINAID HOSPIT	MUF BALTIMURE, 240	IW. BOWEDE	RE AVE BAL	TIMORE MD
(0	31. Date filed (Month, Da	O 00 002. Registar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	aryland		artment of F rtificate of I		Mental Hy	2	010	11.711.		
			Registrar 1. Decedent's Name (First, Middle,	J = -41		Cei	unicate of t	Jeann	2. Date of De	Reg. No.	010	3. Time of Death		
	Physici	an	Patricia Ann Crous						Month May2, 2		Year	8:30 A M		
	/Medio		4a. Facility Name (If not institution,				4h City Town or	Location of Deatl	1		inty of Death			
	Examir	ier		« Memorial Hospital Frederick										
	Funeral			,	e (In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, D		ederick 9. Bjrth	place (State or Foreign		
	Director		174-30-9281	1□M 2√□F	72	Yrs.	Months Days	Hours Min.	Oct 6, 1	937	Cou	PA		
_	P.		Usual Residence of Decedent		1									
	arylar show	-	10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits 1 □ Yes 2 □ No		
	he M	Director	MD Frederi	ck	Free	derick	401 7: 0-1-			40 014	-f M/h - t O - t			
	with th		10e. Street and Number				10f. Zip Code			10g. Citizen		intry?		
	eath v	Funeral	30 North Place	12. Was Decedent	Ever in LLS	13 1	21701 Was Decedent of H	ienanic Origin? (S	necify Ves or No	US.	A Race - Amer	ican Indian		
	item item	표	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	Armed Forces?		13.	f Yes, specify Cuba	in, Mexican, Puert	o Rican, etc.)		Black, White,			
036	irs af	by	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 □Yes 2x1xNo	Specify:		Spe	ecity: W	hite		
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ont, the Medical Examinar must be notified at	Completed	15. Decedent's	Education		16a. Dece	dent's Usual Occup	ation	delan	16b. Kind o	f Business/Ir	ndustry		
21	thin 7 e. an "r	lg l	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. I	kind of work done of DO NOT use retired	l) ()	KING					
	ed wi	ပ္ပ	12			Cafe	eteria Work			Public		System		
pu	be file	Be	17. Father's Name (First, Middle, La	st)				18. Mother's Nar	ne (First, Middle	, Maiden Suri	name)			
yla	ould Mer narke	မ	Paul Jerry Coltus					Dorothy						
Maryland	12 sh hand 7 Is n traun	p 1	19a. Informant's Name/Relationship		Î		ng Address (Street				wn, State, Zi	ip Code)		
	1 and Healt em 2		Denise Blaker 20a. Method of Disposition	Daughter	20h Pia		emacolin Rd sition (Name of	., Carmiche	Date PA,		on - City or T	own State		
ō	ages int of t: If its		1 ☐ Burial 2x ☑ Cremation 3		cer	netery, cren	natory`or other plac				ore, MD	,		
Baltimore,	4 Donation 5 Other (Specify)								ŕ					
Ba	Departiment Departiment Departiment Departiment Departiment Department Depart		K, Gregory Fink	The second secon	1146	F	ink Funera 126 Crain H	I Home, P./		MD 2106	1			
		_		nplications that caused	the death.		er the mode of dyin	g, such as cardia	or respiratory a			Approximate Interval Between		
	Physician	9	Immediat Cause (Final disease or condition											
	/Medical		resulting in \ ath)	a. Due to (or as	a conseque	nce of):	7	1				orgs.		
	Examiner		Cognoptically list conditions	h.	for	Um	e to	the	ince			weeks.		
	D #	iner	Sequentially list conditions, in any, learning to infinite liate cause. Enter Underlying Cause (Disease or injury that initiated events	Dee to (or se	a conseque	nce of):	1							
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	m	Jor	all	un	~			gens.		
60,	icate be executed physician and s the burial-transit			Due to (or as	a conseque	nice ory.								
58760,	ficate phys the	dical		d				Miles 4-4						
_	leath certifi attending for use as	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnance	Су				23d.	Date of deli	verv		
Box	Physician: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use as	Physician/Me	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic pregnance Other (specify)	y			Month	Day Year		
P.0	at the deby the tached	hys	9 Unknown	9 🗆 Unknown										
	s tha	by P	Part II. Other significant condition	s contributing to death b	ut not result	ing in the ur	nderlying cause give	en in Part I.	23e. Did	tobacco use o	contribute to	the cause of death?		
ğ	w requires been sign should be	ed							1 🗆	Yes 2 □ N	o 3□ Pro	bably 4 Unknown		
Records,	slawre hasbe e 2 sho	Completed							24a. Was		4b. Were aut	opsy findings available ompletion of cause of		
<u> </u>	The cate h	ĕ							perfo 1 □ Yes	ormed? 2 No	death?	2 □ No		
Vital	sician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?					26. Place of Dea	ath (Check only	one)				
of \	Physi this c		1 Yes 2 1 1 1 1 1 1 1 1 1 1 1 1				nt 3 DOA Othe	4 🗆 Indianing i	lome 5 Res			rify)		
Ë	ding F n. After funera	ioi:	27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Inju (Month, Da	ıry y, Year) 2	8b. Time of Injury	Work		28d. Describe	how injury oc	curred			
isi	Attending r death. ector: After by the fune	icat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no		ury - At hom	e farm str		Yes 2□No	28f Location	Street and Ni	umber or Bu	ral Route Number,		
Division	l or Atten after deatl Director:	Certification: To	4 ☐ Homicide determin	building, et	c. (Specify)	io, iaiii, ou	eet, factory, office		City or To	wn, State)	arribor or ria	ar riouto rearibor,		
	Hospital or 24 hours afte Funeral Dire tely filled in I			Physician: To the best										
	To the Hospital or within 24 hours after To the Funeral Direct completely filled in the state of	Medical	(Check only 2 Medical E:	aminer: On the basis of		on and/or in	vestigation, in my o	pinion, death occ	urred at the time	, date and pla	.ce, and due	to the cause(s)		
	To the I within 2 To the I complet	Σ	29b. Signature and title of certifie	1111			29c. License			29d. Date si				
	7		/ //	ecc		100 TANKERO	D:	2649	7	5	3-10	>		
	21		30. Name and address of person w	^										
(J V		31. Date filed (Month, Day, Year)	S. F. Registr	ar's Signatu	×177	1							
	Sta Registr		MAY 12 2010	Genevas 1	D. 4	ark								
			376/6 - 77 6010	/	* #									

Registrar DHMH 17 Rev 1/2001 10-03502 Howard Cox Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 0 1 0 147

		1- For State Registrar		Cer	tificate of	Death			Reg.	No.		
Physici	an/	1 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year Month Day Year										
ledical Exami	ner	4a. Facility Name (if not institution				b. City, Town, o	r Location of		May 6, 2010	4c. County o	0750 hrs	
		3988 Ellendale Farm	Drive			Rock Hall				Kent		
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs. la 78	ist birthday)	If Under 1 Year		24Hrs. 8. Min.	. Date of Birth (MM/DD/YYYY)	 Birthplace (State or Foreign Country) 	
Director		222–18–4758	1 XM 2 F		Yrs		, , , , , , , ,		<u>09/07/1</u>	931	DE	
any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Locati	on					10d. Inside City Limits	
	_	MD Kent			k Hall						1 Yes 2 X No	
Aaryland 28a-f show 1 at once	cto	10e. Street and Number				10f. Zip Code			10g.	Citizen of Wha	at Country?	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland and 27 is marked other than "natural", or items 23a or 28a-f sho frammatic event, the Medical Examiner must be notified at once.	Director	3988 Ellen Fa	rm Drive			21661				USA		
with ms 23 be no	eral	11. Manital Status		cedent Ever in U.S		Decedent of Hi					American Indian, Black,	
death or ite	Funeral	1 Never Married 2 XM	I 1 X Yes	2 No		es, specify Cuba		Puerto Rica	an, etc.)	White,		
s after ral",	by		orced If Yes, Give Yes or Dates:			Yes 2 X No			4	ороолу.	White	
2 hour "natu Exar	ted	 Decedent's Education (Spe Elementary/Secondary (0-12) 				i's Usual Occupa ost of working life				6b. Kind of Bus	iness/industry	
5-0036 led within 72 Hygiene. other than '	Completed	12	30095 (H + E F	Farm Equ	ipment			Owner		
21215-0036 Juld be filed within 7 I Mental Hygiene, i marked other than ic event, the Medical		17. Father's Name (First, Middle	, Last)				18.Mother's	Name (Fir	st, M iddle, Mai	den Surname)		
be fill prize	Be	Lee R. Cox					Grace					
Should nd Mol	ဠ	19a. Informant's Name/Relations			A.					•	, State, Zip Code)	
, MD and 2 sho salth and em 27 is		Jeffrey Cox 20a. Method of Disposition	(Son)	20h P	335 S	Laughte	r Stat	ion I	Road, H	<u>[artly, </u>	DE , 19953 City or Town, State	
Ore		1 X Burial 2 Cremation	n 3 Removal fr	om State Cr	rematory or oth	er place)				Dover,		
Baltimore, MD 21215-003 Departinent of Sel and 2 should be filed within Department of Sel and 2 should be filed within Important: If item 27 is marked other the injury or other traumatic event, the Med	- 8	4 Donation 5 Other Sp 21. Signature of January Service		Sna		1 Mem.	cuii.	J=12-				
Ba perm Depa Impo	, I	21. Signature of direction	Timothy S	S. Harman	I	ader Fur		Home		us Stre		
Physician		23a. Part I. Enter the disease, or	complications that c			e mode of dying	, such as card			DE <u>19</u> , shock, or hear	t Approximate Interval	
Medical	(Y 3)	failure. List only one cause Immediate Cause (Final disease	I I and I delice	/ complicating	Hypertens	sive Atheroso	clerotic Ca	ardiovas	cular Disea	ise	Between Onset and Death	
Examiner		or condition resulting in death)		consequence of)	:							
	Ē	Sequentially list conditions,	b. Due to for as a	consequence of							_	
10	Ĭ.	cause. Enter Underlying Cause (Disease or injury that initiated	c						_			
ed sit	Examiner	events resulting in death) Last	Due to (or as a	consequence of)	:							
(Acords, P.O. Box 68760, he law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial - transit		UNPENDED	d									
760, ficate be exe g physician at the burial -	/Medical	IF FEMALE:		outcome of pregna	ancv					23d. Date of d	elivery	
587 crtifica ling pl		23b. Was decedent pregnant in the past 12 months?	1 Live b	irth	2 Fet	al death 3	Ectopic p	regnancy		Month	Day Year	
Box 687 e death certification at the attending ed for use as t	sicial		known 9 Unknown	ant at time of dea	th 5 Oth	er (Specify)						
j, P.O. Baires that the designed by the	Phy	Part II. Other significant condit			sulting in the ur	nderlying cause	given in Part I	I.	23e. Did tobac	cco use contrib	ute to the cause of death?	
P.O es that t	þ					, ,			1 Yes	2 ✓ No 3	Probably 4 Unknown	
cords, law require has been si	etec								24a. Was an		ere autopsy findings available	
Division of Vital Records, rad or Attending Physician: The law requir all or Attending Physician: The law requir all Director: After this certificate has been seled in by the funeral director, page 2 should the funeral director, page 2 should the funeral director.	Completed				-			- 1	autopsy performe	d? de	ior to completion of cause of eath?	
tal Re- tian: The certificate		25. Was case referred to medica				26.Place	e of Death (Cl	heck only	1 Yes 2	No1 [Yes 2 No	
Vital ysician: his certifi director,	o Be	examiner? 1 ✓ Yes 2 No	Illegalist.	npatient 2 E	ER/Outpatient		Othor	Nursing Ho		sidence 6	Other: Scene	
ing Ph.	-1	27. Manner of Death	28a. Date	of Injury	28b. Time of In	jury 28c. Inju	ry at Work?		. Describe how	injury occurre	d	
ion tendii eath. tor: A	텵	1 Natural 5 Pend 2 ✓ Accident Inves	fing FOUND stigation May 6, 2		FOUND: 0740 hrs	1 1	Yes 2 🗸 No	lo Suc	oject fell			
ivis or At after d Direct	Certification:	3 Suicide 6 Coul	d not be 28e. Plac	e of Injury - At hor		t, factory, office t	ouilding, etc.				or Rural Route Number, City	
Spital nours filled	Cer	4 Homicide deter	rmined (Specify)	Single Fami	ily			3988	or Town, State 8 Ellendale F	árm Drive, R	ock Hail, MD	
Divis To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	ical	(Check only Certifying Pi	nysician: To the bes mîner:Dn the basis o									
To T Com	Medical	29b. Signature and title of certifie	and manner s	tated.		29c. Licens				_	(Month, Day, Year)	
	5.7	frant &	Mall in	1		O.C.	M.E.		N	Лау 7, 2010		
101		30. Name and address of person	who completed caus	e of death (Item 2	23a)							
101		Pamela E. Southall, M	•	Medical Exam		Penn Stree	t, Baltimor	re, MD 2	21201			
St Regist	~~~	31. Date filed (Month, Day, Year)		gistrar's Signature	1. ba	Kel						
						ACC AND ARE						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** JOHN CRAFT 12:34 AM MAY 6 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** JOHNS HOPKING BAYVIEW MEDICAL CENTER BACTIMORE Baltimore City 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. **™** M 2□ F Maryland Director 213-34-6438 9,1936 Feb. Usual Residence of Decedent 10a. State show 10b. County 10c. City. Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Exp., it are must be profited at Director 1 ☐ Yes 21 No MD Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 7004 Brentwood Avenue 21222 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2y⊟dNo Specify: þ Specify: 3₺ Widowed 4 Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Machinist Steel Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental H Mildred A. Nelson Shreeve D. Craft ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an item 27 is Julie A. Craft (Daughter) 454 Abbey Circle Abingdon, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp. 5/10/2010 Towson, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial intarction 24 Hours /Medical Due to (or as a consequence of): Examiner bronan arten disesse 30 YEAR Se uentiall, list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): burial-trar physician and Due to (or as a consequence of): Physician/Medical the attending p as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month ☐ Pregnant at time of death 5 Other (specify) P.0. ed by the a 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>À</u> Hypertension, congestive heart failure 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? acute renal 24a. Was an cate has t autopsy To the Hospital or Attending Physician: The performed' certificate 1 XYes 2 □ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar

SUSAN QUAN 31. Date filed (Month, Day, Year) MAY 12 2010

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

29c. License number

RES-000

4940 EASTERN NENUE, BALTIMORE, MD 21224

6,2010

10-03463 Richard Camata	ماد			e or Print in						_egibl	e.	
Richard Comsto	CK,	1- For State	Sta	ate of Marylar		artment (ertificate (nd Mental	Hygiene	Dec No.	201	0 1471
Physicia	an/	1. Decedent's Nan	ne (First, Middle	e,Last)					2. Date of I			3. Time of Death
Medical Exami	ner		EARL	COMSTOCK,					Month May 4,	2010	Year	2108 hrs
		4a. Facility Name Howard Co	,	n, give street and num	ber)		4b. City, Town, Columbia	or Location of De	eath		c. County of De Howard	eath
Euporol		5. Social Security			Age (In vrs	last birthday)	If Under 1 Y	ear If Under 24	Hrs 8 Date of			Birthplace (State or
Funeral Director		086-42-9		1 M 2 F	60	•	Months D			24,	Fo	reign Country) New Yor
		Usual Residence	of Decedent	rM 2_F		Υ	rs.		7	/		Country)
any		10a. State	10b. County		10c. City	, Town or Loca	ation	_				10d. Inside City Limit
Maryland 28a-f show any <u>d at once.</u>	ō	MD	Howa	rd	La	urel						1 Yes 2 XXN
Mary r 28a-	Director	10e. Street and Nu		Gt-			10f. Zip Code				izen of What C	country?
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ath w	Funeral	11. Marital Status 1 Never Marri	ied 2 Ma	12. Was Deced	ces?	If	/as Decedent of P Yes, specify Cub			No-	14. Race - An White, etc	nerican Indian, Black, c.
fter de		3 XWidowed	4 Divo	1XX Yes orced If Yes, Give Year		971 992 1	Yes 2XX N	lo specify:			Specify: V	White
ours a	d by	15. Decedent's E	ducation (Spec	rify only highest grade		16a. Decede	ent's Usual Occup			16b. I	Kind of Busine	ss/Industry
16 n 72 h isan "n ical E	Set	Elementary/Sec Grade 12	, , ,	College (1-4	or 5+)			ie. DO NOT use	retired)		OD	
OO3 withi	Completed	17. Father's Name		l ast\		Ana	alyst	18 Mother's Na	ame (First, Midd		OD Surname)	
215. e filed tal Hy ked of	Bec			stock, Sr.					Jayne Sr		ourname	
213 ould b d Men s mar	2	19a. Informant's Na	ame/Relationsh	nip (Type, Print)		19b. Mailir	ng Address (Str	eet and Number	or Rural Route I	Number, C	ity or Town, St	ate, Zip Code)
MD 21215-0036 nd 2 should be filed within 7 ath and Mental Flygiene. m 27 is marked other than aumatic event, the Medica		Mark A.		ck / son			3 Hadlei					
Baltimore, MD 21215-0036 Dermit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho njury or other traumaite event, the Medical Examiner must be notified at once.		20a. Method of Dis		3 Removal from	n State	crematory or c		- 1	Date			or Town, State
LimC Page ment tant: or ot		4 Donation 5	Other Spe	ecify:	Me	0.000	dge Mem		/13/2010			Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	ineral Service I	Licensee	/ 1/0		Name and Addre					
Physician	\dashv	23a. Part I. Enter th	ne disease, or o	complications that cau		0770 ·	313 Talb the mode of dyin	ott Ave g, such as cardia	nue Lau	irel, arrest, sho	Maryla ock, or heart	and 20707 Approximate Interva
/Medical.	ļ	failure. List or Immediate Cause	nly one cause o	on each line. a. Atheros	clarat	ic car	diovacci	lar dic	0250			Between Onset and Death
Examiner	- 1	or condition resulti		Due to (or as a co			ulovasci	itai uis	ease			1
	Ļ	Sequentially list co		b		0						
	Examine	if any, leading to in cause. Enter Under (Disease or injury)	erlying Cause	c.	onsequence o	or);						
1 g g g	Xar	events resulting in		Due to (or as a co	onsequence o	of):						
ox 68760, and certificate be executed attending physician and for use as the burial - transition.	g	X UNPENDED	-	d								
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587 ertifica ling ph		23b. Was decedent past 12 months		1 Live birtl	h	2 🔲 F	etal death 3	Ectopic pre	gnancy	1250	Month	Day Year
Sox 6 leath cer e attendi for use	sici		No 9 Unkr		nt at time of de	eath 5 O	ther (Specify)			1		
P.O. B. that the de detached f	Phy	Part II. Other signi	ficant condition			esulting in the	underlying cause	given in Part I.	23e. Die	d tobacco	use contribute	to the cause of death?
P.C.	۵								1 🔲	Yes 2 ✓	No 3 P	robably 4 Unknown
ords, w requir	Completed	-							24a. W			autopsy findings available
e law te has ge 2 sl	g E									topsy rformed?	death'	
Vital Rec ysician: The l his certificate l director, page		25. Was case refer	red to medical				26.Plac	ce of Death (Che		s 2 N	0 1	Yes 2 No
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate betwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the burn	To Be	examiner? 1 Yes	2 No	Hospital: 1 Inp	atient 2 🗸	ER/Outpatien	t 3 DOA	Other ₄ Nur	sing Home 5	Reside	nce 6 Ott	ner:
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Sior Nttend death. ctor:	Certification:	2 Accident	5 Pendii Invest	igation				Yes 2 No				
Division of At a fired of in by	Ĕ	3 Suicide	6 Could	not be	of Injury - At he	ome, farm, stre	et, factory, office	building, etc.	28f. Location or Town		nd Number or I	Rural Route Number, City
Di lospital t hours a uneral I		4 Homicide 29a. Certifier ₁		ysician: To the best o	f my knowled	ge death occu	rred at the time	data and place of	and due to the es		d mannas as at	atod
To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 ✓		niner: On the basis of e	examination a							
To To	Me	29b Signature and	title of certifier	and manner state	1 1v	10. I	29c. Licen	se number		29d. [Date signed (M	Month, Day, Year)
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4	ŀ			vho completed cause								
W		Victor Weed		Assistant Medi			Penn Street,	Baltimore, M	D 21201			
Sta	ite	31. Date filed (Mont	th, Day, Year)	32. Regis	strar's Signatu	he. V.	,					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** $11:20P^{M}$ LOIS E. CUNNINGHAM 2010 May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HARFORD BET, ATR AVONDELL Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🖾 F 89 June 30, 1920 Pennsylvania Director 162-12-9196 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examinar must be rotified at 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 21015 128 West Ring Factory Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) <u>File Clerk</u> Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental Olga-Glenn Rowe ပ Burns T. Ernest Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 to Department of Health an Important: If item 27 is any Injury or other trau 727 Burgh-Westra Way, Abingdon, Maryland 21009 Kay Shaffner / Daughter Baltimore. Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 ☑ Removal from State Westminster Presby. Cem. 5-14-10 Mifflintown, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part1. Enter the Lisease, or complications that caused the de. th. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Filure. List only one cause on each lin Immediate Cause (Final **Physician** arter disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of imply that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physlcian: The law requires that the death certificate be executed attending physiclan and for use as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown I ementes Completed 24b. Were autopsy findings available prior to completion of cause of death? HJ N 24a. Was an autopsy performed? CHE 1 ☐ Yes 8 ☐ No 1 ☐Yes 2 ☐No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Living & Senior 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending Housing 1 ☐ Yes 2 ☐ No Investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2010 3225) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Be 1 7 1 - 10 CIT 31. Date filed (Month, Day, Year) State MAY 12 2010 Seners D. Jack Registrar DHMH 17 Hav 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5/9/2010 Day 12:10 AM Lurena Garber Condon Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Northampton Manor Frederick . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Min (Month, Day, Year) Director 212-50-1810 93 MD Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Westminster MD Carrol1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4122 Ridge Road 21157 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give Specify: White 3XXWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Her Home 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Elizabeth Rippeon Charles Garber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 Flower Ct., Mt. Airy, MD 21771 Charles Condon/Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Taylorsville Cemetery: 5/12/2010 Taylorsville, MD Signature of Euro 2Burrler Que Entry Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Dementio Medical Due to (or as a conseque Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to for as a consequent signed by the attending physician and a be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 f yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L Fetal deal 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Year Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Librilotio Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should been s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an pay tension this certificate has autopsy perform death? 1 Yes 2 No Yes funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: ည 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ▼ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) . Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at After 28d. Describe how injury occurred 1 Natural 5 Pending 1 🔲 Yes 2 🗌 No Accident Investigation within 24 hours after deatl To the Funeral Director. Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only on 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signa and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Thomas

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink, Fraure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Carrol1 2 Date of Death David 3. Time of Death Physician/ May 3, 2010 11:30a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore N/A 3039 Arunah Avenue 8. Date of Birth (Month, Day, Year 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Funeral 1 M 2 D F Months Days Hours Min. Director Maryland 216-62-3092 Mar 1, 1952 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 ☐ No N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3039 Arunah Avenue 21216 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces þ Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Box Factory Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alethia A. Carroll William Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 130 West Hamburg Street Baltimore, Maryland 21230 Denise Carroll 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/06/10 Catonsville, Maryland Metro Crematory, Inc. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A Eutaw Place Baltimore, Md 23a. Part v. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Pnysician/ disease or condition resulting in death) years Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending 1 Yes 2 No Acciden Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) yanne Smoot, CRNF K112789 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Veanne Smoot, CANP Univ. of Maryland 22 S. Greene 31. Date filed (Month, Day, Year) State 2 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	Ce	rtificate of Death	1	Reg	No.	
Physici Medical Exam		1. Decedent's Name (First, Middle, Last)	DOVIS			2. Date of Death Month D April 28, 20	Day Year	3. Time of Death 1434 hrs
		4a. Facility Name (if not institution, give University Hospital	street and number)	4b. City, To	own, or Location of Dea		4c. County of Deal	h
		5. Social Security Number 6. Sex	7 Age (In see			rs. 8. Date of Birth	N I	rthplace (State or
Funeral Director		348-30-4883	7. Age (In yrs.	last birthday) If Under Months			Forei	
any		10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits
*	ctor	Balling Balling	more D	Wings 10f. Zip C	Mills	1100	. Citizen of What Cou	1 res 2 No
death with the Maryland or items 23a or 28a-f sho must be notified at once,	al Director	9304 Dwings	Chare	Ct ,	21117		UST-	}
15-0036 filed within 72 hours after death with the Maryland Hygiene. of other than "natural", or items 23a or 28a-f she i. the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married	I2. Was Decedent Ever in U Armed Forces? 1 Yes 2 You Yes, Give Year		t of Hispanic Origin? (: Cuban, Mexican, Puer No specify:		14. Race - Ame White, etc.	rican Indian, Black,
urs aft tural"	d by	15. Decedent's Education (Specify only	r Dates:	16a. Decedent's Usual O	<u> </u>	f work done	6b. Kind of Business	/Industry
6 72 ho an "na	lete	Elementary/Secondary (0-12)	College (1-4 or 5+)		ing life. DO NOT use re	etired)	1 1	1
003 within giene.	Completed	12		Labor		(_	CHION
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner.	Be C	17. Father's Name (First, Middle, Last)	H unkr	own	18.Mothers Nam	ne (First, Middle, Ma	iden Surname) Ma	ybell Davis
Me Me Si	Jo.	19a. Informant's Name/Relationship (Typ		19b. Mailing Address	(Street and Number or	Rural Route Number	er, City or Town, State	e, Zip Code)
Md 2 alth :		20a. Method of Disposition	daughter	Place of Disposition (Name		Date UNK 2	OWINGS	Mills, MD
Baltimore, permit. Pages I a Department of He Important: If ite				crematory or other place)	or cometery,	Pate (IT)	Baltim	
Baltimore permit. Pages I Department of I Important: If injury or other	ć	21. Signature of Funeral Service Ucense	Indel		ddress of Facility	lowell F	Aire. Pa	, Home
Physician		26a. Part I. Enter the disease, or complic failure. List only one cause on each			dying, such as cardiac			Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease a. M	ultiple Injuries					Death
		or condition resulting in death) Sequentially list conditions, b.	e to (or as a consequence o	of):				
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated c.	e to (or as a consequence o	rf):				
executed an and al - transit		events resulting in death) Last Du	e to (or as a consequence o	rf):				
. is is	n/Medical	UNPENDED X	MENDED & 18 pe	er Fh G903 5	/27/10 T T			
∞ ± ∞ ≤	M/M	DOL MAKE deserted to the second to the	23c. If yes, outcome of preg 1 Live birth	nancy 2 Fetal death	3 Ectopic pregr	ancy	23d. Date of deliver Month	y Day Year
ion of Vital Records, P.O. Box 687 tending Physician: The law requires that the death certificate has been signed by the attending I we funeral director, page 2 should be detached for use as the funeral director, page 2 should be detached for use as the funeral director, page 2 should be detached for use as the funeral director.	Physicia	1 Vos. 3 No 0 University	4 Pregnant at time of de				0)	
P.O. Es that the gned by the e detached	by Ph	Part II. Other significant conditions co	entributing to death but not re	esulting in the underlying c	ause given in Part I.		cco use contribute to	
S, P quires t an sign	ted t			-				bably 4 Unknown
of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should t	Completed					24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
tal Rec		25. Was case referred to medical		26	Place of Death (Check	1 Y Yes 2		es 2 No
Vital ysician: his certif director,	o Be		pital: 1 Inpatient 2 🗸	ER/Outpatient 3 DO	IOthor ==		sidence 6 Othe	r.
n of Viding Physi	Ë	27. Manner of Death	28a. Date of Injury (Month, Day Year) Apr 28, 2010	4440 1:	c. Injury at Work?	28d. Describe how		by another vehicle
Division safer death. al Director: A led in by the fu	catic	2 Accident Pending Investigation			1 Yes 2 ✓ No	that was eludir	ng police	
Divi	ertification:	3 Suicide 6 Could not be determined	(Specify) Local Stree	ome, farm, street, factory, o et	mice building, etc.	or Town, State		aral Route Number, City
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: /	Medical C	20a Codifier	To the best of my knowledge the basis of examination a					
To To Com	Med		d manner stated.		icense number		9d. Date signed (Mo	
		Patrucia (Ino	nico - KA	laha	D.C.M.E.	A	April 29, 2010	
	Ì	30. Name and address of person who con			in Street Baltima	re MD 21201		
\$	ate	Patricia Aronica-Pollak MD. 31. Date filed (Month, Day, Year)	Assistant Medical E		n Street, Baltimo			
Regist		MAY 100						l l

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ . 60 YOM Medical 4a. Facility Name (if not institution, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death altmore Funeral 6. Sex 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth 1 🗆 M 2 🗔 Months Days Hours Min **Director** Usual Residence of Decedent items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Xes 2 No to more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 12. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes Give Black 3 Divorced 4 Divorced Specify: Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Dulti More Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Juneral Service Lice 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year Unknown th but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Was autopsy performed? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 (2 No 1 Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending work? injury Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 5 who completed cause of death (Item 23a) (Type, Print) 3

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - For State Registrar			-		e of Dea		vientai my	Reg. No	201	0	14723
Physic /Med		1. Decedent's Name (First, Midd	DAVIS						2. Date of De Month	eath Da		Year	3. Time of Death
Exami Funeral	ner	4a. Facility Name (If not institution Baltimore Wo 5. Social Security Number	shington 6. Sex 7.	•	d Cerast birthday)	Her If Under	G/en 1 Year If L	Buch I	e	F	County o	f Death	rundel
Director		158-52-9906 Usual Residence of Decedent	1 M 2 TF	58	Yrs.	Months	Days Ho	ours Min.	8. Date of Bir (Month, Da Oct 3	1, 19	51	Cour	place (State or Foreign ntry) Dominican Re
e Marylan ka-f show	Director	MD Howar		10c. City, Jessi	, Town or Lo up	ocation		_				1	0d. Inside City Limits 1 □ Yes 🏋 No
th with the	ral Dire	10e. Street and Number 7535 Montevideo Ct				10f. Zip	Code 794			10g. Ci	tizen of Wh		itry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it to Madical Examinating the netfined at once.	by Funeral	11. Marital Status 1XXNever Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	If Vac Give	is? ∰No		Was Deced If Yes, spec 1 □Yes 2		nic Origin? (Spexican, Puerto eecify:	pecify Yes or No Rican, etc.))-	14. Race Black, Specify:	White,	etc.
permit. Pages I and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, Ite Musical Exertitions.	Completed	15. Decede (Specify only highe Elementary/Secondary (0-12) N/A	nt's Education st grade completed) College (1-4c	or 5+)	16a. Dece (Give life.	kind of wor DO NOT us	l Occupation k done during e retired)	most of work	king		and of Busi	ness/Ind	lustry
e filed y al Hygi I other vent, II	Be Co	17. Father's Name (First, Middle	Last)			N/A	18.1	Mother's Nam	e (First, Middle		N/A Surname))	
d Ment d Ment narkec	오	Cecil Davis						Ynes S					
nd 2 shullth and 27 is n		19a. Informant's Name/Relations	, , , ,						ral Route Numb		or Town, S	tate, Zip	Code)
Pages 1 ar nent of Hea nnt: If item iry or other		Francisco Davis 20a. Method of Disposition 1 □ Burial ② □ Cremation 4 □ Donation 5 □ Other (3		te Bayv		sition (Nam			, MD 207 Date 0, 2010	20c. L	ocation - C	•	wn, State
permit. Departri Importa any inju		21. Signature of Funeral Service	Cicenii, e		22	Fink F		Home, P		MD	21061		=-
Physician		23a. Part L Enter the disease, shock, or heart (ailule. Li. Immediate Lause (Fin disease or andition resulting in d. th)	on v one cause on each	sed the death.		er the mode	of dying, suc	ch as cardiac	en Burnie or respiratory a	rrest,	21061		Approximate Interval Between Onset and Death
/Medical Examiner	iner	Sequentially list conditions, if a.y, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	as a conseque as a conseque	ence of):			E			,		5 YEARS
rifficate be executed g physician and as the burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or a	as a conseque	ence of):								
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The law requires that the de tite has been signed by the s age 2 should be detached f	ò	Part II. Other significant condition				nderlying car	use given in F	Part I.		obacco (/es 2		_	e cause of death?
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Physician: This certific	o Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☒ No	Hospital:	ıtient 2 ☐ Ei	P/Outpation		Other:		h (Check only o				
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tal or Attencrs after death al Director: ed in by the	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 28e. Place of I	njury - At hom etc. (Specify)	e, farm, stre	eet, factory,	office		28f. Location (S City or Tow	Street an vn, State	nd Number)	or Rura	Route Number,
To the Hospital or A within 24 hours after To the Funeral Direct Completely filled in by	edical	29a. Certifier 1 Certifylr (Check only one) 1 Medical	CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and do and manner stated.							ner as st	ated. the cause(s)		
To t with COE	Σ	29b. Signature and title of certifie	certifier 29c. License number NOO 62714							te signed (i			
My V		30. Name and address of person	who completed cause of			Print)		•			223		
m v	6	GUILLERMO JO. 31. Date filed (Month, Day Year)	SE GUAD GRECO 32. Regis	trar's Sign atu	9704	TALD	RIVE	CLEHI	JIUAU1E.	MO	2016	1-1	503
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Davis, Bessy

10-03533 Christy L. Dow

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State of Maryland / Department of Health and Mental Hygiene

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Cinisty L. Dow		1- For State Registrar	Stat	te oi iviaryia		epartmen Certificate			a ivier	ıtaı Hyg	_	Reg. No	2U I	U	14/24
Physicia Madical Eveni	an/	Decedent's Name		Last)							2. Date of Dea Month	ath Day			3. Time of Death
Medical Exami	ner	CHRISTY L 4a. Facility Name (i		give street and nu	mber)		T 4b. Cit	ty, Town, or	Location		May 7, 20	010	c. County of		1030 hrs
			neral Hospita	-			Bei		Local	0, 0			Worceste		
Funeral		5. Social Security N	lumber 6.		7. Age (In yr	rs. last birthda		Inder 1 Year			8. Date of 8i	irth(MM	A/DD/YYYY)	Foreign	
Director		149.66.08 Usual Residence of	0.10	1 M 2√X F	3	35	Yrs.	Illuia Ca,	, 1100.	5 197	SEP. 2	27,	1974		untry) NJ
/ any		10a. State	10b. County		10c. C	City, Town or L	ocation			`					10d. Inside City Limits
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with the	ra D	1045 11th 11. Marital Status	AVE.	12. Was Dec	edent Ever ir	ın U.S. 13	. Was Decr	1980 edent of His		igin? (Sper	cify Yes or No	0-	USA 14. Race -	- Americ	can Indian, 8lack,
death or item	Funeral	1 Never Marrie		ried Armed Fo	orces?	lo	If Yes, spe	ecify Cuban	, Mexicar	n, Puerto Ri			White,		
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21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co	17. Father's Name (ıst)				1			First, Middle, I	Maiden	n Surname)		
212 rould be id Ment is mari		DENNIS W. 19a. Informant's Na		(Type, Print)		19b. M	ailing Addre	ess (Street		DA J. F mber or Rur	PELIEN ral Route Nur	mber, C	City or Town	State,	Zip Code)
MD and 2 sheath an em 27 i		DENNIS W.		FATHER	120	157 Ob. Place of Dis					T MYERS		33908 Location - 0		Chata
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 XXBurial 2	Cremation				or other pla		песегу,		Jate	200.	Location - c	ity or i	own, state
altim nit. Pa sartmen portani	1	4 Donation 5 21. Signal re of Fu	Donation 5 Other Specific FRANKLIN MEMORIAL PARK MAY 13, 2010 NORTH BRUNS 3 rap re of Funeral Servicy Lichnique 22, Name and Address of Facility FINK FUNERAL HOME, P.A.										UNSW	TCK, NJ	
Der Der Inji		Muck	K. ACRECOND FUNK MO1148 FINK FUNERAL HOME, P.A. 426 CRAIN HWY. S., GLEN BURNIE, MD 21061 Part I. Enter if e Viseas A complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart												
Physician Medical	a	favure. List of I	ly one call se on	each line.				le of dying,	such as c	ardiac or re	espiratory arr	rest, she	ock, or hear	t	Approximate Interval Between Onset and Death
Examiner		Immedi t. Cause (F or condition resultin		a. Fentan Due to (or as a			<u>ion</u>							\dashv	Deau
	<u>_</u>	Sequentially list cor		b. Due to (or as a	consequenc	on offi								\dashv	-
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	n/Me	IF FEMALE: 23b. Was decedent p	pregnant in the	23c. If yes, o	outcome or pr	regilaticy	Fetal dea		_	ic pregnance		23	Bd. Date of d	lelivery Da	ay Year
lox 68 eath certi	Physician/	past 12 months	_	4 Pregna	ant at time of	f death 5	Other (S			o programa,	у	ļ	MOUTH	0.	ly roa
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Division of Vital Records To the Hospital or Attending Physician: The law requi within 24 hours after death. To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should	Be	25. Was case referre examiner?		Hospital: 1	anationt 2	✓ ER/Outpat	tiont 3		of Death Other	(Check only		Paside	ence 6	Other:	
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D To the Hospital within 24 hours To the Funeral completely filled	ا ا ا	4 Homicide 29a. Certifier (Check only 1		sician: To the best				the time, dat	te and pla						
To the Hospi within 24 hou completely fil	Medical	one) 2 🗸	Medical Examin	ner: On the basis of and manner sta	f examination	-	tigation, in i	my opinion,	death oc			and pla	ace, and due	e to the	cause(s)
	Σ	29b. Signature and t	title of certifier	dans	3		2	29c. License O.C.N					Date signed y 8, 2010	,	h, Day,Year)
300	-	30. Name and addre	ess of person wh	n completed caus	a of death (It	em 23a)			1			Ivia	y 0, 2010		
P		Carol Allan,	MD Assist	stant Medical E			ın Street	, Baltimo	re, MD	21201					
St	ate	31. Date filed (Month	1 2 7 7/11	32. Reg	gistrar's Signa	ature pav	Re								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 29b c per DVR g903 5/12/10 TT State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 3Ó 3010 6:00 AM April Deborah Davis /Medical 4c. County of Deatl 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3729 Beehler Avenue Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 9. Birth Social Security Number 7. Age (In yrs. last birthday) (State or Foreign **Funeral** 49 Days 1 □ M 2 🔽 Tune Director Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Expressiver must be notified at 1 tes 2 No Director laryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cubap, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Specify: Black 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 ☑No ≥ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other than any injury or other traumatic event, Item 2008. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be Annie Mae Williams ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 Ave. Fair DOKS 20b. Place of Disposition (Name of cemetery, crematory or other place)

M. Ziow Cemetery Method of Disposition 1 ■ Burial 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lices 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TASTA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 No 1 ☐ Yes of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 6 2010 D47934 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PL. BALTIMORE 31. Date filed (Month, Day, Year) egistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** BERTHA TOOTS MAY 2010 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Augsburg Lutheran Home Gwynn Oak If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11–22–1925 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 1 F Director 212-26-8383 Usual Residence of Decedent .1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

Health and Mental Hygiene.

tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, It a 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 ☐ Yes 2 No Gwnn Oak Baltimore MD **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21207 USA 1900 Hillcrest Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No _{Specify:} African-American Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Damestic 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bessie Carter Samuel Gee ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1900 Hillcrest Road, Gwynn Oak, MD 21207 Linda Black/ Daughter permit. Pages 1 an.
Department of Healt.
Important: if item 27
any Injury or other tra 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-17-2010 Garrison Forest Veterans Owings Mills, MD 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. Co. 21. Signature of Funeral Service Licenses 9200 Liberty Road, Randallstown, MD 21133 23a. Parl 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strick, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death HTHEROSCHE ROTIL EREBRED VASCULAR 1)1SEASE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Physician/Medical Examiner ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Vear 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 Other (specify) P.0. been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2 No 1 □ Yes 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2□No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 27. Manuar of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After Natural Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours after To the Funeral Direct 4 ☐ Homicide Certifier
(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Check only one) 29a. Certifier Medical 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 29c. License number asheen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	,	State of Maryla	•	artment of He			2011	14727
		Registrar 1. Decedent's Name (First, Middle, Last)	001	uncate of Be	Julii	2. Date of Dea	Reg. No	3. Time of Death
Physici		Maddalena F. Ferretti				Month May 8,	2010 Year	9:44 P M
Medi Exami		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or L	ocation of Death	<u> </u>	4c. County of Dea	ath
		8516 Howell Road		Beth	nesda		Montgom	ıery
Funera Director		5. Social Security Number 6. Sex 7. Age (In yrs 1 1 1 M 2 X F 82	. last birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day March 25	9. Bi Year) 928 It	irthplace (State or Foreign ountry) aly
- MC	١.	Usual Residence of Decedent		<u> </u>				1
ryland -f sho	ct	10a. State 10b. County 10c. C	City, Town or Lo		D .1 1			10d. Inside City Limits 1 Yes 2 No
r 28a notifi	Director	Maryland Montgomery		10f. Zip Code	Bethesda		10g. Citizen of What C	
/ith th	<u>ra</u>	8516 Howell Road			0817		United Sta	*
eath v	Funeral	11 Marital Status 12. Was Decedent Ever in U	J.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,		cify Yes or No-	14. Race - Am	erican Indian,
fter de , or it	by	1 Never Married 2 Married Armed Forces2 1 Yes 2 No If Yes, 2 Value 1 Yes, 2 Value 1 Yes, 2 Value 1 Yes, 3 Value		ir Yes, speciiy Cuban, 1 ☐ Yes 2 🏿 No		Hican, etc.)	Black, Whi	te, etc.
UCES A LUIS A LU	ted	3 Li Widowed 4 Li Divorced Year or Dates.						nite
T5- T2 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupati kind of work done dui O NOT use retired)	ion ring most of worki	ing	16b. Kind of Business	Industry
Z1Z15-UU36 within 72 hours after gjene. er than "natural", o	ပ်	Elementary/Seconday (0-12) College (1-4 or 5+) 5+		am Directo	or		Education	ı
filed v al Hyg	Be	17. Father's Name (First, Middle, Last)		1			Maiden Surname)	
ylar d be d Menta	은	Luigi Funciello			Carmel:	a Minoza	zi	
Baltimore, Maryland Z1Z15-UU30 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print)					City or Town, State, Z	
e, R and 2 Health em 27		Aldo Ferretti / Husband 20a. Method of Disposition 20b		HOWELL KO			ary1and 20	
nt of l		1 Burial 2 X Cremation 3 Bemoval from State	cemetery, crei	matory or other place)		Date	Bethesda, 1	
ITIN nit. Pa artmei ortani injury		4 ☐ Donation 5 ☐ Other (Specify) Mor		Crematorium,			_	
Den Den da any ence		M013		bert A. Pump 57 Wisconsin	hrey Fune Avenue, B	eral Home/ ethesda.l	Maryland 208	evy Chase, Inc. 14-3501
		23a Part 1. Enter the disease, or complications that caused the de						Approximate
Ph sician	/	shock, or hearf failure. List only one cause on each line. Immediate Cause (Final disease or condition Colon	Cancer	•				Interval Between 3nset and Death 1ears
Medica Examine		resulting in death) a. Due to (or as a conse						
LAdiiiiie		Sequentially list conditions, b.						
ped sirt	Examiner	if any, leading to immediate Due to (or as a consecute Cause. Enter Underlying Cause (Disease or Injury	equence of):					
xecut r and al-trar	Exa	that initiated events resulting in death) Last C. Due to (or as a conse	equence of):					
50 Ite be e hysicial	dical	d						
8/6 tiffcate ng ph	Med	IF FEMALE:						
BOX 687 death certifice the attending properties as its for use as its form.	ian/	23b. Was decedent pregnant in the past 12 months?	etal death 3	Ectopic pregnancy			23d. Date of d Month	elivery Day Year
bo dear	Physician/Me	1 Yes 2 No 4 Pregnant at time of g Unknown	of death 5 L	Other (specify)	,		World	Day
that the		Part II. Other significant conditions contributing to death but not	esulting in the	underlying cause give	n in Part I.	23e. Did to	bacco use contribute t	to the cause of death?
S, Lires t 1 sign	ed by		107			1 🗆 ነ	∕es 2X No 3□	Probably 4 🗆 Unknown
w req	Completed					24a. Was a		utopsy findings available completion of cause of
HeC The la ate ha	l E					perfor	rmed? death?	
cian:	Be (25. Was case referred to medical examiner?			e of Death (Check	k only one)		
PV;	은	1 Yes 2 X No	ER/Outpatie		4 ☐ Nursing Ho		ence 6 Other (Spe	ecify)
nol	Sate	1 X Natural 5 ☐ Pending (Month, Day, Year)	injury	work?	es 2 🗆 No	28d. Describe h	ow injury occurred	
Atten r deat r deat octor:	Certificate:	2					treet and Number or R	ural Route Number,
Division of Vital Records, tal or Attending Physician: The law requires to after death. I Director: After this cartificate has been signed in by the funeral director, page 2 should be din by the funeral director, page 2 should be death.		building, etc. (Spec	eify)			City or Tow	n, State)	
Division of Vital Records, P.O. Box 68/60 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifler (Check (Check 2 Medical Examiner: On the basis of examinar	ion and/or inves	stigation, in my opinion,	, death occurred at	t the time, date a	nd place, and due to the	e cause(s) and manner stated.
thin 2 ithin 2 the I	ž	only one) 3 Certifying Nurse Practioner: To the best of 29b. Signature and the of certification of the control of the certification of	my knowledge,	death occurred at the t			e cause(s) and manner a 29d. Date signed (Mon	
ద≯≒న		->/ (anc 4 11/11	MD	DC6			May 10, 20	
70		30. Name and address of person who completed cause of death (It	em 23a) (Type,				• • • • • • • • • • • • • • • • • • • •	
20		Nancy Falk, M.D. 2311 M St.	, NW, W	lashington	, D.C. 2	0037		
	ate	31. Date filed (Month, Day, Year) 32. Registrates Sign	nature	bares				
Regist	rar	WAY 1 2 2010 - Paren	a B.	1 ann				

DHMH 17 Rev 7/2009

0-03372 Stephen Northrop	p FI	Please Type or Print in Black Indelible Indelible Indelible Index State of Maryland / Department or			ible.	11-70
·		1- For State Certificate Of Registrar	_	Reg	g. No.	14/2
Physicia Medical Examir		1. Decedent's Name (First, Middle,Last) Steven N. Fletcher		2. Date of Death Month May 2, 201	Dav Year	3. Time of Death 1316 hrs
)			4b. City, Town, or Location of Death Germantown	, 2, 20	4c. County of Death Montgomery	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 214-70-3928 1 X M 2 F 50 Yrs	If Under 1 Year If Under 24Hrs. Months Days Hours Min.	7	(MM/DD/YYYY) 9. Birth Foreign er 23,1959 Cou	
daryland 28a-f show any 1 at once.	Director	Usual Residence of Decedent 10a. State	Germantown		g. Citizen of What Count	10d. Inside City Limits 1 Yes 2 No
with the P s 23a or e notifie	ral Di	20028 Wanegarden Court 11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa	20874 as Decedent of Hispanic Origin? (Spe		nited State	
after death vall, or item	by Funeral	1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates:	Yes, specify Cuban, Mexican, Puerto \mathbb{R} Yes $2 \overline{X} $ No specify:	Rican, etc.)	White, etc. Specify: W	hite
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland ant of Health and Mental Hygiene. It: If item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	nt's Usual Occupation (Give kind of w nost of working life. DO NOT use retin Ount Executive		16b. Kind of Business/In	·
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	a	17. Father's Name (First, Middle, Last) Corbin Fletcher		et C. Ne	edling	
MD 2 id 2 shoul lith and M m 27 is m summatic	ို		g Address (Street and Number or R Kirtley Trail, (. ,
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposic crematory or different state Gate of H	sition (Name of cemetery, her place) Leaven May]		20c. Location - City or T Silver Spri	
Baltimo permit. Pag Department Important: injury or ot		21. Signature of Funeral Service Licensee Ro	hame and Address of Facility bert A. Pumphrey West Montgomery Aver	Funeral	Home/Rocky	ille, Inc.
Physician Madical Examiner		23a Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive atheros	he mode of dying, such as cardiac or	respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate Due to for as a consequence of it.				
1/3 · 26 · 181	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):				
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Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be exhin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician applietely filled in by the funeral director, page 2 should be detached for use as the burial		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Female at time of death	tal death 3 Ectopic pregnar		23d. Date of delivery Month Da	y Year
, P.O. Box 68: rres that the death certifi signed by the attending be detached for use as i	۵	Part II. Other significant conditions contributing to death but not resulting in the concerning alcoholism	ınderlying cause given in Part I.		acco use contribute to the	
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Vital Recc ysician: The lav his certificate ha	B.	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient	26.Place of Death (Check of DOA Other, Nursing		esidence 6 🗸 Other:	Scene
Division of Vippital or Attending Physicours after death. Peral Director: After this filled in by the funeral directorial dir	ation: To	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation			w injury occurred	
Divisior Hospital or Attent 24 hours after death Funeral Director:	Certification:	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, stree (Specify)	7	or Town, Sta		
To the Hos within 24 h To the Fur	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigat and manner stated.	tion, in my opinion, death occurred at	the time, date an	nd place, and due to the	cause(s)
15	2	29b. Signature and title of certifier Theodor M. King They are.	O.C.M.E. OCME		29d. Date signed (Mont May 3, 2010	h, <i>D</i> ay, Year)
oxyend.			111 Penn Street, Baltimore.	, MD 21201		
Sta Regist		31. Date filed (Month, Day, Year) 32. Registrarts Signature	back			
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Depar		•	
			1 - State Registrar 1. Decedent's Name (First, Middle, Last)	ificate of Death	Reg. No	
ı	Physici		DAVID O. FELDMANN		Month Day	9. 2010 1 55 M
3	/Medi Examir			4b. City, Town, or Location of Death	4c.	. County of Death Pm .
			COURTLAND GARDENS 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	PIKESVILLE If Under 1 Year If Under 24 Hrs. 8	B. Date of Birth	ALTIMORE (State or Foreign
	Funeral Director			Months Days Hours Min.	B. Date of Birth (Month, Day, Year) 05/16/1920	9. Birthplace (State or Foreign Country) M
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc.			10d. Inside City Limits
	Mary B-f sho	tor	MD BALTIMORE PIKESV	IIIF		1 □ Yes 2(1) No
	or 28	Funeral Director	10e. Street and Number	10f. Zip Code	10g. Cit	izen of What Country?
	eath v	erai	31 SADDLE COURT 11. Marital Status 12. Was Decedent Ever in U.S. 13. W.	21208	fu Vas or No	USA 14. Race - American Indian,
ဖွ	or iten	Fun	1 Never Married 2 Married 1 V Yes 2 No	as Decedent of Hispanic Origin? (Speci Yes, specify Cuban, Mexican, Puerto Ri	can, etc.)	Black, White, etc.
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "neturel" or items 23e or 28e-1 show event. The Mydical Exarcilier must be natified at	ed by	3 Wildowed 4 Divorced Year or Dates:	☐ Yes 2 1 No Specify:		Specify: WHITE
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21	filed with Hygiene. Ither the		4 REAL	ESTATE BROKER		AL ESTATE
and	should be filed within and Mental Hygiene. marked other then metic event, the Mental treatments.	To Be	17. Father's Name (First, Middle, Last) BENNO FEL DMANN		First, Middle, Maiden	
Maryland	s 1 and 2 should f Health and Men item 27 is marke other treumetic	F	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or Rural F	FRANK Route Number, City o	
	s 1 and 2 if Health item 27 i		4	DDLE COURT, PIKES		21208
Baltimore,	90=5		W☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crema	tory or other place)		ocation - City or Town, State
altir	그 든 된 글		21. Signature o Funeral Servi e Licensee 22.	HEBREW CEM.05/11/2 Name and Address of Facility SOI	2010 IREIS LEVINSON	& BROS., INC.
8	Department of the services once			O REISTERSTOWN ROA	AD, PIKESV	
	-		23a. Part Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	Λ		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death) Due to (or as a consequence of):	under accide	مار	< 6mm/1-
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68760	9 2 0	dical	d			
Вох 6	leath certificat attending phy I for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
	e death he atte	sicia	in the past 12 months? 1 Yes 2 No 1 Yes 2 No	ctopic pregnancy Other (specify)		Month Day Year
P.0	that the de ed by the detached		9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the und	erlying cause given in Part I	23e. Did tobacco u	use contribute to the cause of death?
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Division of Vital	fte and	on: I	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 1 Injury		d. Describe how injur	
isio	Attending in death. ector: After by the fune.	ficati	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injury - At home farm stree	M 1 Yes 2 No	Location (Street an	nd Number or Rural Route Number,
3	tel or / rs after el Dire ed in b	Certification:	4 Homicide determined building, etc. (Specify)	, rudory, ones	City or Town, State	
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the to	edical	29a. Certifier (Check only one) 1 ☐ Certifying Physicien: To the best of my knowledge, death of the basis of examination and/or investant manner stated.	ccurred at the time, date and place, and stigation, in my opinion, death occurred	d due to the cause(s) at the time, date and	and manner as stated. It place, and due to the cause(s)
	To the To the comp	Ž	29b. Signature and title of certifier	29c. License number	29d. Dat	te signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	Duy & 17	1.00	10.00
			2434 Li Returbre all	Rethinen	his a	1247
**	Sta Registr		31. Date filed (Month, Day, Year) NAY 12 2010 2. Registrar's Signature			

David Feldman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Manth 14 32 M Physician Harrison 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Ye 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f show notified at 10a State 10b. County 10c. City, Town or Location Yes 2 □ No Funeral Director timore 10g. Citizen of What Country ö ms 23a or Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 ☐ No Specify ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education Medical (Specify only highest grade completed) Elementary/Secondary (0-12) other than the Mother's Name (First, Middle, Eather's Name (First, Middle, Last) Be ည 19a. Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Method of Disposition 20b. Place of Disposition (Name of cemeters, crematory or other p Department of H Important: If ite any injury or ott once. 1 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Serv MO155 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Aspiration disease or condition /Medical resulting in death) Due to (or as a consequence of) **Examiner** cal ance Sequentially list conditions, Examiner ue to or as a consequence of cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed that initiated events the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 2 No page 2 should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 XNo 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence Hospital: 2 (No 1 Ninpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA မ 6 Other (Specify) Director: After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 X Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury or Attending 1 Yes 2 No death. filled in by the 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Hospital 29a. Certifier (check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Virthin 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Res - 000 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U | U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** GRONBERG MILDRED 06:20 AM 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE GENESIS PERRING PARKWAY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5 Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖾 F Days Hours Director 90 10-15-1919 Maryland 214-03-4461 Usual Residence of Decedent 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experies must be notified as 1 XYes 2 No Director MD Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21224 528 S. Macon Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: If Yes, Give Year or Dates: þ Specify: White 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Goetze's Candy Machinist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wolf Elizabeth Edward Kellner Mae ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s. Department of Health ar Important: If item 27 is 1 any Injury or other traus 3709 Timahoe Circle Perry Hall Md. 21236 - Son Eugene C. Gronberg 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 5-13-10 Baltimore, Maryland Baltimore Nat. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph N. Zannino Jr. F.H. 21. Signature of Funeral Service Licensee 263 S. Conkling Street Balto.Md. 21224 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Immediate Cause (First ALZHE IMER'S DEMENTIA **Physician** Vegras disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical attending properties for use as as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month in the past 12 months? Year Day 5 Other (specify) P.0. 1 ☐ Yes 2 🗷 No the 9 Unknown 9 Unknown ģ s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, HYPERTENSION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed ANEMI 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has t page 2 s autopsy performed? 1 □ Yes 2 🗷 No certificate ! To the Hospital or Attending Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To After this funeral d 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director A
completely filled it by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗷 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 th MAY Sama Khomal D0058965 1801 WENTWORTH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

KHAWATA, M.D.

MAY 12 2010 Gener S. Sak

BALTIMORE

MD 21234

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ М Medical 4a. Facility Name if not institution, give street and number, 4b. City, Town, or Location of Death County of Death **Examiner** more 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 👿 F Hours Min. Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director 1X Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code Apt. 10g, Citizen of What Country? Funeral , or items 23a 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. "natural", 3 ☐ Widowed 4 X Divorced Year or Dates. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturally injury or other traumatic event, the Medical once. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura oute Number, City or Town, State, Zip Code) (niece) e Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location 1 X Burial 2 Cremation 3 Removal from State Donation 5 Dother (Specify) Funeral Service Licensee Signa Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ CARDIOMYOPATHY disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subsetex \text{ No} \) Month 5 Other (specify) Pregnant at time of death signed by the a 1 Yes 2 A 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been s 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 **K** No 1 Yes 2 No Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 **X** No 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined edical 29a. Certifier 1 🔲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 K Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2010

DHMH 17 Rev 7/2009

State Registrar JENNI FER

2010

TIMONIUM, MD 21093

of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD

who completed c

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HAUF,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10:28 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's 7828 Quill Point Drive Bowie 8. Date of Birth (Month, Day, Jan. 25. 6. Sex 1 ☐ M 2 Ø F Funeral Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days Hours Min. Pennsylvania Director 82 <u> 928</u> 163-22-3987 Usual Residence of Decedent shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1**X**□ Yes 2 □ No Prince George's Maryland Bowie 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 7828 Quill Point Drive Bowie 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Teacher's Aid Child Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Vernon Bitts Ida Carpenter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7828 Quill Point Drive Bowie, MD 20715 Corinne R. Grim/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 To Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) May 12, 2010 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or imjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknow Part. U. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 5 - Residence 6 Nother (Specify) DAUGHTER'S 2 No 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of HOME 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signat e and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print MD

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day ZUIU Physician/ May 3 55 VILLA 1541 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Season's Hospice Randallstown Baltimore 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🗓 F Hours Min (Month, Day, Year) 9 05 **Director** 214-56-7358 61 09 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No MD Baltimore NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6717 Longhill Road 21207 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 X Married ☐ Yes Yes, Give 2**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Business Representative Verizon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Harrison Emma Madison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Longhill Road, Baltimore, <u>James Glenn-Husband</u> 6717 Md 21207 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Memorial Park 5/14/2010 Woodlawn, Md 21. Si va ure of Funeral Service Licenses 22. Name and Address of Facility
March F/H West
4300 Wabash Av Ave. Baltimore, Md 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ventilatory besi disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, ner Due to (or as a consequence or): cause. Enter Underlying Cause (Disease or linjury Exami the attending physician and hed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Dav Year 2 No To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Metasta 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📉 Unknown Kena 24b. Were autopsy findings available prior to completion of cause of death? hronic performed? Yes 2 K No 1 🗌 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 10 Other (Specify) Hrss. 1 🗆 Yes 2 💢 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State To the Hospital or within 24 hours af To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0053337 Name and address of person who completed cause of death (Item 23a) (Type, Print) 3mith Avenue Baltimore Seay 17000 835 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 15 90 Quar 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Season's Hospice
Social Security Number | 6. Sex Baltimore <u>Catonsville</u> 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Days Hours Min. (Month, Day, Year) Director 3-18-6213 88 **09** 18 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hyglene. Important: If time Z7 is anaked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21216 U.S.A. Gwynns Falls Parkway 12. Was Decedent Ever in U.S. Armed Forces? 1 K Yes 2 □ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 X Widowed 4 Divorced Completed Black Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Post Office 2th grade Postal Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Olive Boyd James Gregory 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Easter-Granddaughter Gwynns Falls Parkway, Baltimore, 3314 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn 5/17/2010 Woodlawn, Md 22. Name and Address of Facility March F/H West 4300 Wabash Av 21. Signature of Funeral Service Licensee 21215 Ave, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a. Part 1 shock Approximate Interval Between Immediate Cause (Final disease Condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): physician and the burial-transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 2 🗌 No been signed by the should be detached 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4★ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Hospital or Attending Physician: The law cate has page 2 s autopsy performed certificate 2 No 1 Yes **Division of Vital** funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Tes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral Natural 5 Pending work? 1 ☐ Yes 2 No Accident Investigation Suicide 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the F 29b. Signature and title of certifie 29c. License number me and address of person who completed cause of death (Item 23a) (Type, Print) Y) 64 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Alvin H. Garrett Month Day 11:15A May 08 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Baltimore County Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days (Month, Day, Hours Director 232-56-7404 70 Clarksburg.W.VA Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Baltimore County Parkton 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral United States 21120 17733 Foreston Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White Specify: Completed 3 - Widowed 4 - Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working I Hygiene. other than " Environmental life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Technologies Vice Pres. Quality Control h and Mental Hygien 7 is marked other thrumatic event, the 12 02 permit. Page 1 and 2 should be filed or Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ray A. Garrett Maxine Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Marie E. Garrett (wife) 17733 Foreston Road Parkton, Maryland 21120 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Location - City or Town, State (Harford Co.) cemetery, crematory or other place, 09,2010 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Evans Funeral Chapel 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Center, P.A. 2325 York Food Timonium, Maryland 21093-2215 Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ unthelia a Metastatic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any local to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last the burial-transi attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day 5 Other (specify) n signed by the all ed f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed? Yes 2 X No death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No Other: ျ 1 Tes 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 IDOA Dico Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 \square Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2. only on 29b. Signature and title of certifier

OTIV

31. Date filed (Month, Day, Year)

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Registrar

ame and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death HOLMES Year Month **Physician** TLLIAN Ma 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** RandallsTown Baltimore HOSPITAL North WEST If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F 135.34.9671 Yrs **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is a marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, he Medical Exprinter must be neithed any injury or other traumatic event, he Medical Exprinter must be neithed at 10c. City, Town or Location 10d. Inside City Limits 10a. State Invings Mills 1 ☐ Yes 2 No **Funeral Director** MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Groffs Mill Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No If Yes. Give Specify: Black Completed by 3 X Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Orange Board Elementary/Secondary (0-12) College (1-4or 5+) of Education Cafeteria Worker 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name First, Middle, Last) Be Lillian Bradtord Kichard Roberts ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Warren, NJ 07059 8 Alane Drive scott Holmes 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5 15 2010 Ovange, N. J. 22. Name and Address of Facility Yangha C. Greene Funeral Services 21. Signature of Funeral Service Licensee de 8728 Liberty Road Randalistaun MD 21133 23a. Part 1. Enter the dicease, or complications that caused the death. Do not enter the mode of dying, such all cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final Encephalopathy **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner End Stage RENAL DISEASE Sequentially list conditions, if any, learning to infine liate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an 2 2 No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D65843 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 Old Court Road, Rendalls town, HD 21133 0/ Katrouri Abda/lah

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Regist ar's Signature

2010 ▶

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Eacility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Butmure Bultimore Strew Social Security Numbe Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, 1 M 2 🔀 Days Hours Min. Director 213-20-3993 86 Usual Residence of Decedent or 28a-f show 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2X No Baltimore Gwynn Oak Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 USA 1960 Featherbed Lane 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: SpeBlack Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Seconday (0-12) College (1-4 or 5+) Research Analyst Dept. of Aging Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Amy Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1960 Featherbed Lane Baltimore, MD 21207 Clifford E. Hazel/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/8/10 Woodlawn, Maryland Moodlawn-Cemetery 22. Name and Address of Facility Chatman-Harris Funeral Nome Signature of Juneral Service Licensee 240 Reisterstown Rd Baltimore, MD 21215 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each line Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 attending physi IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? 2 No 9 Unknown Division of Vital Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an as e 2 , page certificate 2 No Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Merry Hospital: Other: 2 XNo ၉ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Acther (Spe 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide M Investigation within 24 hours after death

To the Funeral Director: A 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Day 2010 Pear May 11 Agnes Viola Haines 1:50A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll
 If Under 1 Year
 If Under 24 Hrs.
 8. Date of Birth (Month, Day, Year)

 Months
 Days
 Hours
 Min.
 (Month, Day, Year)

 1 0 / 5 / 1 9 2 5
 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🕱 F 219-20-1919 84 Director MD Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Carroll MD Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1034 Old Manchester Rd. 21157 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 ₺ Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Housewife 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Page 1 and 2 should be fill ment of Health and Mental ant: If item 27 is marked ဂ္ Chester Williams Dora Beard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Stem- daughter 305 Bellview Ave., Mt. Airy, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If its any injury or of 1 Burial 2 Cremation 3 Removal from State 5/13/10 Westminster, MD 4 Donation 5 Other (Specify) Krider's Cem. 22. Name and Address of Facility Fletcher Funeral Home 21. Signature of Faneral Service Licensee Homas Z 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ 2astric (a disease or condition 4-15-10+03/4/D Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): physician and s the burial-transit Exami that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) signed by the and be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign 1 Yes 2 No 3 Probably 4 nknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of autonsv performed? Yes 2 death? 1 🗌 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 N N ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 De Other (Specify) DOVE HOUSE 27. Manner of Deeth 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No Accident Investigation ☐ Accider ☐ Suicide the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) erson who completed cause of death (Item 23a) (Type, Print) MSTHIUSTER, MIDOLOS State

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Nealand Lewis Hunt 03:25 A M May 4. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours August 17, 1926 New Hampshire 83 Director 008-16-4068 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 4909 Bangor Drive 20895 United States be filed within 72 hours after death 11 Marital Status 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian. Armed Forces?

1 A Yes 2 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married 2 No Maryland 21215-0036 WWII 1 ☐ Yes 2 X No Specify: If Yes. Give Specify:White "natural" Completed 3 X Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. I o**ther than** " Elementary/Seconday (0-12) College (1-4 or 5+) 12 Chief of Maintenance National Institutes of Health Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Walter Hunt Esther Strong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Binder/Daughter 2125 Abbot Way, Woodstock, Maryland 21163 Baltimore, 20b. Place of Disposition (Name of Commetery, Crematory or other place)
Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State May 8, 2010 4 Donation 5 Other (Specify) Bethesda, Maryland Robert A. Pumphrey Funeral Home/Rockville, Inc. M01530 300 West Montgomery Avenue, Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Myocardial Infarction disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Cornary Artery Disease Sequentially list conditions Due to for as a consequence of if any leading to immedicause. Enter Underlying Cause (Disease or iinjury Exami attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death the 9 🗌 Unknown g Unknown ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been signer should be or Attending Physician: The law requires Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perforn yeriormed? Yes 2 1 No certificate 1 Yes 2 No hours after death.

neral Director: After this certific
d filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🛛 No ၉ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 🔲 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours aft

To the Funeral Di

completed filled in Medical 1 **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 **Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) duesto 100 680 80 May 4, 2010

Registrar

State

2011

9901 Medical Center Drive, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Fegistrar's Signatu

Sireesha Jalli, M.D.

31. Date filed (Month, Day, Year) **ANY 12 2010**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MOnth ELEANOR 04:00P M HARRIS 2010 Medical 4a. Facility Name (if not Institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HEART HOMES ASSISTED LIVING BALTIMORE LUTHERVILLE 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) MD **Funeral** 1 M 2 X F Days Min 04716 1917 212-01-9339 93 Yrs. Director Usual Residence of Decedent 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d, Inside City Limits Director 28a-f 1 Yes 2 X No MD BALTIMORE LUTHERVILLE ō 10e. Street and Numbe 10f. Zip Code ritems 23a or ner must be n 10g, Citizen of What Country? Funeral 1420 FRONT AVENUE 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 6 ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Nidowed 4 Divorced Completed Specify: WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be permit. Page 1 and 2 shruid re filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other are 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည SOLOMON LURIE HANNAH COHEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELAINE KATZ / DAUGHTER STILL FOREST ROAD. BALTIMORE. 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State BETH TFILOH CONG. 05/11/2010 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) catz Medical ue to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to in modiate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a son sequence of): Exami and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ the Hospital or Attending Physician; The law requires thin 24 hours after death. Completed 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Jas autopsy 2 No Yes 1 Tyes Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital ass wird IVII 2 X No ျှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 🗆 29b. Signature and title of certifier 29d. Date signed (Month, Day, Yea Mal ss of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month_ Year **Physician** 90 2010 5 Ohnson ache /Medical Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner If Und Date of Birth Month, Day, Year 05-05-2010 Birthplace (State or Foreign Country) . Age (In vrs. last birthday **Funeral** 1 □ M 2 □ 🔀 n/a Yrs MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 No **Funeral Director** Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 14. Race - American Indian, 21207 2705 A Gatehouse Drive Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2☐ If Yes, Give Year or Dates: X Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: African-American Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation II a
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Christopher Johnson Lakebria T.Austin 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2705 A Gatchouse Drive, Baltinore, MD 21207 19a. Informant's Name/Relationship (Type. Print) Lakebria Tanjamek Austin/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. 5-13-2010 Metro Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. Co. 21. Signature of Funeral Service License 9200 Liberty Road, Randallstown, MD 21133 23a. Part/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician TRE /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) P.O. Box 68760. as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Linknown 9 Unknown signed t I be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 3□ DOA 2 ER/Outpatient Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending investigation 1 🗌 Yes To the Hospital or Attendi within 24 hours after death.
To the Funeral Director: A completely filled in by the fi 2 No death 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of sertifier 29c. License number 29d. Date signed (Month, Day, Year) China, MD 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARBUR HOSPITA IWITNA 31. Date filed (Month, Day, Year) 32. Degistrar's Signature State

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DHMH 17 Rev 1/2001

Registrar

			For State	State of Ma	arylan	-	rtment of H		ind M	ental Hyg	iene	nin	14	743
			Registrar 1. Decedent's Name (First, Middle, Last)			Cer	tificate of L	Jeath			eg. No	0 1 0	T	7 7 0
	Physicia Medic		James John	ison						2. Date of Deat Month MaV	08.	2010	3. Time of 5:55	
	Examin		4a. Facility Name (if not institution, give stre	et and number)			4b. City, Town, or	Location of	Death			inty of Death		
الو ا			Gilchrist Hospi	ce Cent	ter		Towso	on			Balt	timor	e	
	Funeral Director		5. Social Security Number 6. Sex 1 🔼 N		(In yrs. le 85	st birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours		8. Date of Birth 0^{Month}	^V 235	g. Birthi Coun	olace (State o try) AL	r Foreign
	*		Usual Residence of Decedent											
	yland f shc ed at	ż	10a. State 10b. County		,	, Town or Loc						1	0d. Inside Cit	-
	Mar 28a- notifi	Director	MD Baltimon	re	C.	atons							1 🗆 Yes	A △ No
	th the	al [10e. Street and Number				10f. Zip Code			1		of What Cour	ntry?	
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0	or ite	by Fi	1 Never Married 2 X Married	Armed Forces?	do). If	las Decedent of Hi Yes, specify Cuba	n, Mexican,	Puerto R	ican, etc.)	14. F	Race - Americ Black, White,	etc. Afr	ican
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Z	filed within 72 hours after death with the Maryland flat Hygiene. All Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	Elementary/Seconday (0-12)	College (1-4 or 5-	-)	life. DC	NOT use retired) Rewin	_	or woman		h omn	son S	too1	Co
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lland	should be filed within 72 hours after n and Mental Hygiener 7 is marked other than "natural", or raumatic event, the Medical Exami	인		nson				Este			homa			
ar	should and N is ma	318	19a. Informant's Name/Relationship (Type,	Print)		19b. Mailin	g Address (Street a	and Number	or Rural i	Route Number,	City or Towi	n, State, Zip (code) 21	228
≥,	nd 2 in m 27 i		Myrtle Johnson-	Wife			andolph	Spri	ings					MD.
9	ge 1 a t of H		20a. Method of Disposition ★XBurial 2 □ Cremation 3 □ Rer	noval from State	20b. P	lace of Dispos emetery, crem	sition (Name of atory or other place re Nat	e)				on - City or To		
baltimore,	t. Pag rtmen rtant: rjury		4 ☐ Donation 5 ☐ Other (Specify)		Ва					4-10		imore		
<u> </u>	permit. Page 1 and 2 should be fi Department of Heath and Menta Important: If item 27 is marked any injury or other traumatic ev once.		21. Signature of Funeral Service Licensee	James			Name and Addres			lie Fu				
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5 1	or Arthrang Prysician: The law requires that the death certificate be executed firth clear. After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transif	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day,	Year)	28b. Time of injury	28c. Injury work? M 1 🗆		- 1	d. Describe ho	w injury occ	urred		
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2	io the Hospital of Attending within 24 hours after death. To the Funeral Director: After completed filled in by the fune	Medical	29a. Certifier (Check only one) 1 Certifying Physicia 2 Medical Examiner: 3 Certifying Nurse Pr	On the basis of exa	amination	and/or investi	gation, in my opinio	n, death occi	urred at th	ne time, date and	d place, and	due to the car	use(s) and mar	ner stated.
, i	withi To t		29b. Signature and title of certifier	200	7	7	29c. License					ned (Month, I	-	
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•			30. Name and address of person who comp DANIEWE DOBER	eleted cause of dea	ath (Item	23a) (Type, Pr	int) CHARLE	SST. 8	UITE	-4105	BALTI	MOREIN	10 212	04
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DHMH 17 Rev 7/2009

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n of	rding Physician: T th. After this certifica funeral director, p	cate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injui (Month, Day	ry ⁄, Year)	28b. Time injury		28c. Injury work' 1 🔲	rat ? Yes 2 □ No	28d. Describe	how inju	ury occurred		
Division of Vital Records,	To the Hospital or Attending Physician; The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Il Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	be 280 Place of Inju	iry - At ho	ome, farm, s	treet, facto	ry, office		28f. Location (City or To			Rural Route Number,	2
	Hospi 24 hour Funera eted fill	Medical	(Check 2 Medical Exan	ysician: To the best of niner: On the basis of exrse Practioner: To the	xamination	n and/or inve	estigation, in	n my opinio	n, death occurred a	at the time, date	and plac	ce, and due to th	e cause(s) and manner sta	ated.
	To the within 2 To the Comple	Σ	only one) 3 Ly Certifying Nur 29b. Signature and title of certifier				29	c. License	number		29d. D	ate signed (Mo	nth, Day, Year)	
			· te	2				Res	0000	,	1	5-7-	JO10	
	\		30. Name and address of person who	completed cause of de	eath (Item	1 23a) (Type	Print)							_
	\		Dr. Selena Tr 31. Date filed (Month, Day, Year)	32. Registra	1000	DFra	OIL	n 59	uaredr	ive Ba	1+ iv	noie f	UD 3193.	7
	Sta Registra		MAY 12 2010	Dever Service	o Stallat	back	20							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 29d, per MD g903 5/12/10 11 State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year BERT JOHNSON 05 2010 2:150 Medical 06 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1102 Druid Hill Apt 404 ${ t Baltimore}$ Ave Age (In yrs. last birthday) If Unde 8. Date of Birth (Month, Day, Y 04 30 Birthplace (State or Foreign Country) 24 Hrs **Funeral** 1**X**□M 2 □ F Months Hours Min Director Yrs 36 251-50-3918 SC 28a-f shov 10a, State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD NA 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21201 <u>1102 Druid Hill</u> 404 U.S.A. <u>Ave Apt</u> 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give "natural", or \$ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Specify: Completed Black Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 9th grade Construction Worker Construction Co. na Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be Charlie Johnson Martha Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grandter 2522 West Baltimore St., <u>Lucretia Johnson-</u> Baltimore, Md 21223 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Memorial Park 5/14/2010 Woodlawn, Md ing 21. Sign Funeral Service Licensee 22. Name and Address of Facility
March F/H West Wabash timore. 21215 23a, Part 1. Enter the dis se, or complications that ca the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate or heart failure shock . List only one caus on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) the attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? þ be 2 No 1 Yes 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?

Yes 2 No this certificate 1 Yes 25. Was case referred to medical completed filled in by the funeral director. æ 26. Place of Death (Check only one) examiner? ျှ 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of s after death. Certificate: 28c. Injury at 1 Natural 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours after within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only of signed (Month, Day, Year) 29b. Signature 00 161 5/7/2010 Name and address of pe Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 05 **Physician** velyn KINIOD 2-06c /Medical County of Death 4b. City Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c Examiner enesis sevirna Paule severna Par If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 220~01~1793 Director 89 9,1921 Feb. Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-5 show 10c. City, Town or Location 10d. Inside City Limits 10b. County a or 28a-f show t be notified at 10a. State 1**X**Yes 2 □ No Director MarylandBaltimore City Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 USA 4350 Shamrock Avenue ral", or items 23a Examiner must b Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ☐ Yes 2☐XNo f Yes, Give 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify Specify. 3 ☐Widowed 4 ☐ Divorced Year or Dates: White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 6 yrs. College (1-4or 5+) Shoe Company Assembler 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Laura Skillman John Williams 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 8112 Buttercup Lane W. Pasadena , Md. 21122 Carl Kintop, Jr. (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-10-2010 Parkwood Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility €.3 Lassahn Funeral Home 7401 Belair Bd. Baltimore, Md. 21236 assalin Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest; shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ore Therosclar **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ sign be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident the Funeral Director: pletely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined To the Funeral 29a. Certifier 1/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2010 06 R10431 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DIANA NG CRUP

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

1 2 2010

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1222P Audrey Belle Kerns 05/2019-2019 Medical 4b. City, Town, or Location of Death Bel Air **Examiner** 4a. Facility Name (if not institution, give street and number) 4c. County of Death Harford 102 Idlewild Rd Apt 1D 7. Age (In yrs. last birthday) 89 yrs If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Birthplace (State or Foreign Country)
 NC 1 □ M 2 🗓 F Months Days Hours Min. 244-26-7146 09°08°21 920 Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director MD Harford Bel Air 1 🗆 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 102 Idlewild Rd Apt 1D 21014 USA · death v 11. Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

XY Yes 2 No
Yes, Give Black, White, etc 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 within 72 hours after Specify: White 1 🗌 Yes 2 🛣 No Completed 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit, Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) Callege (1-4 or 5+) Seamstress Mens Clothing Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Allen Laura Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myra R. Schwarz (daughter) 2714 48th St. S. Gulfport FL 33711 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State Bayview Crematory 05-12-2010 4 Donation 5 Other (Specify) Baltimore, MD Signature of Funeral Service Licenses 22. Name and Address of Facility MacPhail Rd BelAir, MD 21014 610 W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Chronic Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 prionths?

1 Yes 2 No Day Month Year Pregnant at time of death been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autops\ perforn 1 Yes 2 No Yes 25. Was case referred to medical completed filled in by the funeral director, Certificate: To Be 26. Place of Death (Check only one) examiner? 2 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 27. Manner of Beath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 00058475

Registrar DHMH 17 Rev 7/2009 BIELAZ

ADD GOOD

PHTS ICEAN

602

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's

UIP NIVAT

201

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Manorama K. Kapuria 9. 2010 1802 hrsM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 6. Sex . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2 🛣 F Hours 5-2-1943 Year) 67 Director India 296-06-1592 Usual Residence of Decedent fshow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Examiner must be notified at Director or 28a-f 1 ☐ Yes 2 🛣 No MD Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1831 Crofton Parkway Apt C 21114 India tems 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 9 1 Never Married 2 X Married 1 Yes 2 XNo Completed by Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: "natural", 3 Widowed 4 Divorced Indian Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) pernit. Page 1 and 2 should be filed within 7, Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmets. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ghirdharlal B. Gohil Madhukantag B. Gohil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kantilal J. Kapuria 1831 Crofton Pkwy Apt C Crofton, MD 21114 Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arundel Crematory 5-11-2010 Odenton, Maryland Signature of Funeral Service 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 colu an M01176 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician Ventricular disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** ocardi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events 0 Exami burial-transit Atherosclerotic attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy been signed by the atte should be detached for in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director; After this certificate has been sign 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 2 🗆 № ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann∍ of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical

4

Registrar

29a. Certifier

(Check

only one)

31. Date filed (Month)

29b. Signature and title of certifier

30. Name and address of person

completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

29c. License number

State of Maryland / Department of Health and Mental Hygiene ? for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Khattak Mohammad Nawaz 05 2010 5:12p. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Baltimore Catonsville 1420 Harberson Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Days Hours Min Pakistan Months **Director** 73 216-58-3353 28a-f shov 10a. State 10c City Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director Catonsville 1 ☐ Yes 2 🏅 No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 U.S.A. 1420 Harberson Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 X Married 1 ☐ Yes 2 ☐XNo Specify: Specify: Asian Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Johns Hopkins College (1-4 or 5+) Elementary/Seconday (0-12) 12th grade Hospital Scientist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file h and Mental F 7 is marked ot ဥ Zarif Khan Hazrata 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is 1 any injury or 27 1420 Harberson Road, Catonsville, Md 21228 Samina A. Khattak-Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 5/10/2010 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn, Md Signature of Euneral Service License 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complicat. — that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ satand D disease or condition Medical resulting in death) Examiner bus Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?
Yes 2 No death? certificate 1 Tes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🗷 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) hours after death.

Ineral Director: After this of filled in by the funeral director 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed 1 (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Pay, Year)
05/10/2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) Comp Made Ld linthicon MD 21080 18 filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

10-03340	
Kuen Lee	

0-03340 uen Lee		Please Type or Print in Black Indelible State of Maryland / Department of			n 11.75			
		1- For State Certificate Certificate C		Reg. No.	0 , 9.70			
Physicia Medical Examin	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death 2302 hrs			
medical Examini	CI	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	April 30, 2010 h 4c. County of De				
		8610 Honeysuckle Court	Ellicott City	Howard				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min		Birthplace (State or reigr South Kore			
	E	Usual Residence of Decedent	15.	12/7/73				
w any		10a. State 10b. County 10c. City, Town or Local 10c. City, Town or Loca	ation	·/	10d. Inside City Limits 1 Yes 2 No			
Maryland 28a-f show d at once.	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	,			
a or		8610 HONEXSUCKLE OF	21043	KOR	EA			
tems 2.	Funeral		Vas Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puerto		erican Indian, Black,			
ifter des		1 Yes 2 No 3 Widowed 4 Divorced If Yes Give Year 1 Testering 1	Yes 2 No specify:	Specify:	ASIANI			
11215-0036 Id be filed within 72 hours after femal Hygiene arked other than "natural", arked other than "matural", and the Medical Examiner.	ed by	during	ent's Usual Occupation (Give kind of most of working life. DO NOT use reti		ss/Industry			
36 thin 72 te. than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	1STRUCTION	1 CONSTIL	WE FION			
5-00 led wit Hygien other		17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)				
21215-0036 Juld be filed within 7 Mental Hygiene. Marked other than cevent, the Medica	To Be	19a. Informant's II me/Relationship (Type, Print) WIFF 19b. Mailin	ng Address (Street and Number or I	Rural Route Number, City or Town, Sta	ate Zin Code)			
ages I and 2 shount of Health and It: If item 27 is not other traumatic		MI YEUN LEE 8611	HUNEBOKKE (of ELLICOTECI	HMD21043			
ore, ME es I and 2 s of Health an If item 27		20a. Method of Disposition 20b. Place of Disposition Removal from State 20c rematory or community or commu	osition (Name of cemetery, other place)	Date 20c. Location - City	or Town, State			
		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses 22.	12000	-5-2010 MARRIOTT	SVILLE, MO			
Balti permit. Departm Importa		21. Signature of Furieral Services Licensee	Name and Address of Facility	WETG FUNERIA	1) 7.079if			
Physician	7	23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	the mode of dying, such as cardiac of	or respiratory arrest, shock, or heart	Approxima e Interval Between Onset and			
Examiner	1	Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic car Due to (or as a consequence of):	diovascular disea	ase	Death			
		Sequentially list conditions, b						
	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):							
d ansit		events resulting in death) Last Due to (or as a consequence of):						
	dicar dicar	X AMENDED 23a,27,perME #9 per FH g903 5/	g904 6/7/10 TT 13/10 TT					
3760 ficate b		IF FEMALE: 23c. If yes, outcome of pregnancy	etal death 3 Ectopic pregna	23d. Date of deliverancy Month	ery Day Year			
th certi	Scial	past 12 months? 4 Pregnant at time of death 5 0	ivionity					
D. Bo	Phy Y	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death?			
than det	g o			1 Yes 2 No 3 P	robably 4 🗸 Unknown			
w requir	Completed			autopsy prior to	autopsy findings available completion of cause of			
Rec #	<u>ا</u> ق			performed? death? 1 ✓ Yes 2 No 1 ✓				
/ital	e Re	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatien	26.Place of Death (Check of the 3 DOA Other Nursin	only one) ng Home 5 Residence 6 🗸 Oth	ner: Scene			
of Vital Recoing Physician: The law After this certificate has	- 1	27. Manner of Death 28a. Date of Injury 28b. Time of		28d. Describe how injury occurred				
Sion Attendir death. ector: by the f	왕	A Natural 5 Pending Processing Investigation	1 Yes 2 No					
Divi	ertification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Roof or Town, State)						
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	<u>8</u>	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
To th withir To th compl	ᄝ	2 Medical Examiner: On the basis of examination and/or investigation and manner stated. 29b. Signature and title of certifier	29c. License number	at the time, date and place, and due to				
	-	() (dantabour D)	O.C.M.E.	May 2, 2010	/			
	ŀ	30. Name and address of person who completed cause of death (Item 23a)						
	to	Laron Locke MD. Assistant Medical Examiner 111 Peni 31. Date filed (Month, Day, Year) 32. Register's Signature	n Street, Baltimore, MD 212	01				
Sta Registra	~	MAY 1 2 2010 Pressay A	have de					

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

10-03607 Please Type or Print in Black Indalible link. 5 Figure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Michael Dennis Laub 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month Day May 10, 2010 **Medical Examiner** 1138 hrs Michael Dennis Laub 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death St. Joseph's Hospital **Baltimore County** Towson 5. Social Security Number 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Foreign Months Days Director Hours 1965 517-88-3514 44 Country) Ohio Nov. 14. 1X M 2 F Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 X Yes 2 No N/A Baltimore City Md. permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1660 E. Belvedere Ave. Apt. 25 21239 Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? 1 X Never Married 2 1 Yes 3 Widowed 4 Divorced f Yes. Give Year 1 Yes 2 X No specify: Specify: White \$ 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Design 5+ Mechanical Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be McCarthy Marlow Dennis Sandy ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandy McCarthy/Mother 1609 Dixon Ave. Missoula, Montana 59801 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 K Cremation 3 Removal from State Hilltop Service Corp. 5/12/10 Towson, Maryland 4 Donation 5 Other Specify. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licenses Michael J. Ruck, Jr. per DVR Towson, Maryland 21204 1050 York Road 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** failure. List only one cause on each line (Morfice) Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown detached i P.0 Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 V Unknown page 2 should be Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? 2 No ✓ Yes 2 No 1 🗸 Yes Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) of Vital filled in by the funeral director, Be examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 🗌 DOA Other Nursing Home 5 Residence 6 Other this ٩ 1 🗸 Yes 2 No 28d. Describe how injury occurred After 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? Certification: within 24 hours after death.

To the Funeral Director: All completely filled in by the fur Natural May 10, 2009 Subject climbed rail and jumped from parking 0000 hrs Pending 1 Yes 2 V No garage 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 8000 York Road, Towson, MD determined (Specify) Parking Garage Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) OCME O.C.M.E. May 11, 2010

121

31. Date filed (Month; Dey, Year) 32. Remarks Signature

Theodore M. King, Jr., MD.

Mar's Signature

111 Penn Street, Baltimore, MD 21201

of death (Item 23a)

Assistant Medical Examiner

State Registrar

10-03458 Tony L. Lewis	State Ame 1- For State Registrar Amend 20b&c	of Maryland / Departm nd 20 b&c Per FH per DVR 12/8/PIO/G	lelellink₂ FinsurelAll Copie Bitof Health And Mental H Re of Death	ygiene Reg. No.	2010 14/32
Physician/ Medical Examiner	Decedent's Name (First, Middle, Last	Lewis		2. Date of Death Month Day May 4, 2010	3. Time of Death 1728 hrs
)	4a. Facility Name (if not institution, given 300 Byrn Street	e street and number)	4b. City, Town, or Location of Death Cambridge	1 40	. County of Death Porchester
Funeral Director	5. Social Security Number 6. S 216-82-3497 1	ex 7. Age (In yrs. last birt	hday) If Under 1 Year If Under 24Hrs Months Days Hours Min	_ `	DD/YYYY) 9. Birthplace (State or Foreign Country) Virgina
nd how any see.	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location Rocky Moun	+	10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	10e. Street and Number 134 Parknd	ge Ct.	10f. Zip Code 27804		zen of What Country?
fter death with t I", or items 23s ier must be not		1 Yes 2 No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto No specify:	Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
p, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. tent 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director		or Dates: nly highest grade completed) 16a. College (1-4 or 5+)	Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret	work done 16b. k	Antomofive
ID 21215-0036 should be filed within 72 hou and Menzal Hygiene. 77 is marked other than "nat natic event, the Medical Exa	Eleon Lewis Si	·	Mary	e (First, Middle, Maiden Louse Bi	shop
ore, MD 21 s 1 and 2 should of Health and Me If item 27 is ma	19a. Informant's Name/Relationship (Land Lewis — 20a. Method of Disposition	rother (o. Mailing Address (Street and Number or 1658) Stoney Point among the street and Number or 1600 among the street among the	Rural Route Number, Ci	ity or Yown, State, Zip Code) 23500 No rfolk, VA: Location City or Town, State
Baltimore, pemit. Pages 1 a Department of He Important: If ite	1 Burial 2 Cremation 3 4 Donation 5 Other Specify 21. Signature of Funeral Service Lice	Removal from State		13/2016 Not	as folk Virginia
Physician Examiner	failure. List only one cause on e Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Acute Pontine Hemorrhage Due to (or as a consequence of):	ot enter the mode of dying, such as cardiac o	or respiratory arrest, sho	Ap, oximate Interval Between Onset and Death
xecuted n and I - transit	events resulting in death) Last UNPENDED				
ords, P.O. Box 68760, w requires that the death certificate be execute s been signed by the attending physician and should be detached for use as the burial - tran- oleted by Physician/Medical E	7 1 Yes 2 No 9 Unknow	4 Pregnant at time of death	Fetal death 3 Ectopic pregn Other (Specify)		d. Date of delivery Month Day Year
res that the signed by the lbc detached	Part II. Other significant conditions Hypertensive Atheroscle		use contribute to the cause of death? No 3 Probably 4 V Unknown		
Records, The law require. ficate has been signage 2 should be Completed	Kidney Failure	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
Vital Fysician: ysician: his certifin director, o Be C	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2 ER/O	26.Place of Death (Check utpatient 3 DOA Other Nursi		ence 6 🗸 Other: Scene
Division of Vital Records, P.O. Box 68760, with a Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transledical Certification: To Be Completed by Physician/Medical E.	Accident Investiga 3 Suicide 6 Could no determine	ation 28e. Place of Injury - At home, farm, street, factory, office building, etc.		Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
To the Hospi within 24 hou To the Funer completely fil	29a Certifier	cian: To the best of my knowledge, de er:On the basis of examination and/or i and manner stated.	ath occurred at the time, date and place, and no no not place, and no not place, and not place,	at the time, date and pla	ace, and due to the cause(s)
	29b. Signature and title of certifier	No	29c. Licanse number O.C.M.E.		Date signed (Month, Day, Year) y 5, 2010

DHMH 17 Rev 1/2001 OCME 2006

Registrar

State 31. Date filed (Month, Day, Year)

Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 2016 Theresa V. Luke ar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 0 040 Mare Se da le If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
March 26,1935 If Under 1 Year 5. Social Security Numbe (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Months Days Min. Hours 75 Yrs 212-32-7547 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Madical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No MD Baltimore Edgemere 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9003 Avenue A 21219 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2√ No ģ Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. Elementary/Secondary (0-12) 12 Years College (1-4or 5+) Clerk Loan Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emil Lengrand Theresa Darchicourt ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: If Item 27 is any Injury or other trau once. (Husband) 9003 Avenue A Mr. Travis T. Luke Edgemere, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ₩₩Burial 2 Cremation 3 Removal from State 0ak Lawn Cemeterv 5/10/2010 Baltimore, Maryland 4 ☐ Donation Other (Specify) Sonature 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. uneral Service License Dundalk, Maryland Wise Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a gonsequence of) failure Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con-Examine equence of): the attending physician and hed for use as the burial-trans! Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day signed by the a d be detached fo 5 Other (specify) Ö ☐Yes 2☐No 9 ☐ Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 4 nknown 2 □ No 3 ☐ Probably peen 24b Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an page 2 s certificate has autopsy 2 A No 1 □Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After or Attending 5 Pending investigation 1 Natural Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) filed (Month, Day, 32. Registrar's Signature State 12 2010 Registrar

Funeral Director items 23a or 28a-f show the Medical Examiner must be notified at 5 Baltimore, Maryland 21215-0036 Pages 1 and 2 should be filed vent of Health and Mental Hygir ant: If item 27 is marked other

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records, neral Director: / filled in by the fr within 24 hours a

To the Funeral C

completely filled

20708 10001 Snowden Road U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XX Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2XXMarried 1 □Yes 2 No Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12)
Grade 12 College (1-4or 5+) Owner/Operator Laurel Health Food 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josef Ascherl Maria Bodensteiner ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) partment of Health a sortant: If item 27 is injury or other trau daughter 12002 Tempo Lane Monika Price Bowie, Maryland 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ¥¥Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Meadowridge Mem Pk. 5/14/2010 Dorsey, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee Laurel, Maryland M00770 313 Talbott Avenue 20707 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or o shock, or heart failure. List o mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Immediate Cause (Final Glioblastoma Multiforme months disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🖾 🗓 o 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform 1 ☐ Yes 2**XX**No 2**X X**No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home XX Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐XXX 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 27. Manner of Death 11. Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of c 29c. License number 29d. Date signed (Month, Day, Year) D63470 May 7, 2010 pleted cause of death (Item 23a) (Type, Print) 30. Name and address of per 20 Alfredo Quinones-Hinojosa 4940 Eastern Avenue Baltimore, MD 21224 31. Date filed (Mor egistrar's Signature State Registrar **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** MARIA BARBARA May 2010 8:30 a M LOWE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10001 Snowden Road Laurel Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, You March 4, Birthplace (State or Foreign Country)
_ 5. Social Security Number 7. Age (In yrs. last birthday) Days Year) 1934 1□M 2\XX Hours Yrs. March 214-40-0754 Germany Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 ☑ No Directo MD Prince George's Laurel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#4c, perPHYS, G903, 5/12/2010, WS

State of Maryland / Department of Health and Mental Hygiene 0 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AUBACH Μ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City Town, or Location of Death 4c. County of Death ENTER MAMORE / RHUMP MOCK If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Date of Birus (Month, Day, Year) 1 1988 9. Birthplace (State or Foreign Funeral 1 № M 2 🗆 F Months Days Hours Min Maryland Director 2<u>17-29-5408</u> 21 Usual Residence of Decedent 28a-f shov 10a. State 10b. County ould be filed within 72 hours after death with the Maryland of Mental Hygiene.
marked other than "natural", or items 23a or 28a-f sho 10c. City. Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Maryland | Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21001 705 Mahan Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc Never Married 2 Married þ 1 Tes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Company Electrician Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ John David Laubach Jr. Connie Lynn Cullum and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 s tment of Health a tant: If item 27 i 705 Mahan Road, Aberdeen, Maryland 21001 John D. Laubach / Father any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) Memorial Gdn: 5-14-10 Bel Air, Maryland 21. Signature of Paneral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ HONTER disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINES physician and s the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: The law within 24 bours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2. 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examine? Hospital: Other: 2 🗌 No ဂ္ 1 Propatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 Natural 12/2010 unknown 1 Yes 2 **X**No 2 Accident 3 Suicide 4 Homicide MOTORCYCLE Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

3131 ALDRO RD, MD 766 determined MUNCHURIE Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cortifier completed cause of death_(Item 23a) (Type, Print) 30. Name and address S 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 2010 5:30a Medical Charles awver 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death <u>Catonsvi</u>lle Baltimore <u>55 Wade Ave</u> Cottage Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours 1 XM 2 🗆 F Director 57 223-72-0134 26 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director Catonsville MD Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Completed by Funeral Wade Ave Cottage U.S.A. items ; 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?

1 Ves 2 No
if Yes, Give
Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 9 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural", Specify: 3 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r American Cancer Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Society 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mitchell Lawyer Sr <u>Mary Lou Williams</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21228 Department of Health at Important: If item 27 is any injury or are Anna Lawyer-Wife
20a. Method of Disposition <u>55 Wade Ave, Cottage #16,</u> <u>Catonsville</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Forest 5/17/2010 Owings Mills, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West. Baltimore, Md 23a. Par J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shipt, or heart failure. List only one cause on each line.

Immedia: Cause (Final Interval Between Onset and Death Physician/ disease or condition resulting in death) brain tumor Le MOS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury Due to (or as a consequence of). and -transit that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-1 Physician/Medical attending phy for use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Dav Year 1 Yes 2 9 Unknown signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? or Attending Physician: The law cate has page 2 s performed certificate Yes 2 No 1 Tes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 🗹 No Other: 1 Tyes ည in 24 hours after deatn. he Funeral Director: After this or poleted filled in by the funeral di 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 D0003120 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARE-SPRISE ANE, SUITE 101 5051 GATMORE, MD 2120 Ph.D 31. Date filed (Month, Day, Year) **AAY 12 2010**

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar		State of N	Maryland		artmen tificate			and M		giene Reg. No.	010	14757		
	Physicia		Decedent's Name (First, M. LEONARD	ddle, La	rst)	LAI	N N					2. Date of Dea	th Bay	2010	3. Time of Death 11:37P M		
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上旬	permit. Pages 1 and 2 Department of Health : Important: If item 27 is any Injury or other tra once.		20a. Method of Disposition	7	20b. Place	of Disposition (Name of	7	Date /		cation - City or To	own, State
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Ö	he de the s	ysic	1 ☐ Yes 2 ██No 9 ☐ Unknown	4 ☐ Pregnant at ti 9 ☐ Unknown	me of death	5 ☐ Other (specify)				Month	Day Year
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Ξ	I or Attendi after death. Director: /	ij	4 Homicide determined	28e. Place of Injury building, etc.	- At home, fa (Specify)	rm, street, factory, office	9	28f. Location City or To	(Street and wn, State)	Number or Rura	l Route Number,
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	To the Hospital or Attending Physiclan: The law requires that the death certificate be ewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Me	29b. Signature and title of certifier	O -		29c. Licer	nse number		29d. Date	signed (Month,	Day, Year)
			Janvenie -	Lolomia	1.	1 21	6527		Mar	3 2	010
			30. Name and address of person who	completed cause of deal	th (Item 23a)	(Type Print)	, , ,		- V	1.	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Ull U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Franklin, Meade Month 6:50 AM 05 201 Medical facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death timore CENTER iMORE Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 220-20-330 1 🗆 M 2 🗆 F Days Hours (Month, Day, Year JAN 21 19 Country) Director Usual Residence of Decedent of Health and Mental Hygiene. item 23s or 28s-f show item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the M. dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2XX No ANNE ARUNDEL **PASADENA** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7808 HARBOR RD. 21122 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces' Black, White, etc. Completed by Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 XNo WHITE Specify: 3 WWidowed 4 Divorced Year or Dates. 1947-55 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9 CONSTRUCTION **FOREMAN** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ WILLIAM FRANKLIN MEADE CATHERINE CARRIGAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Department of Health al
Important: If item 27 is
any injury or other trees. DEBBIE CASH DAUGHTER 26037 GAREY RD.. DENTON, MD 21629 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XXBunal 2 Cremation 3 Removal from State 4 Donation 5 Other (Speciment) CROWNSVILLE VET. CEM. MAY 14, 2010 CROWNSVILLE, MD . Sign ture of Funeral Service Liv 22. Name and Address of Facility FINK FUNERAL HOME, P.A. CREGORY FINK M01148 426 CRAIN HWY S GLEN BURNIE MD 21061 Enter the disease, or con heart failure list on cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between cause on each line Cause (Final Immediate¹ Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) inding physician ause as the burial-Physician/Medical death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ☐ Live Birth ∠ ☐ Fregnant at time of death
☐ Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 No Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifies Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: A completed filled in by the fu ☐ Accident ☐ Suicide Investigation 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Yarid 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IDNORTH GREENEST almalk 32. Registrar's Sanature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Morris Month Day Physician/ 2010 OZ15 Ma Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Riverview Nursing Home Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Months Days Hours Min. 08/17/1920 N. Carolina 227-20-1380 89 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director ¶ Yes 2 □ No N/A Baltimore MD ō 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral U.S.A. 3923 Edmondson Ave. 21229 items 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iter dical Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 X Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns
any injury or other traumatic event, the Medic (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday_(0-12) College (1-4 or 5+) 12th Grade Housekeeper Self Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Willie Morris Mannie Perry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas A. Jones (son) Edmondson Ave., Baltimore, MD 3923 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 DiBurial 2 Cremation 3 Removal from State Garrison Forest 05/14/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Name and Address of Facility
Joseph H. Brown Jr. Funeral Home
140 N. Fulton Ave., Baltimore, MD 21217 Signature of Funeral Service Licenses 2448 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ tears disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death sate has been signed by the page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform ☐ Yes 2 ☐ No 2 🗷 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? Hospital 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work' 5 Pending s after death.

I Director: Aff
d in by the fur 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (SpecIfy) within 24 hours after de To the Funeral Directo completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D37573 30. Name and address of person who conause of death (Item 23a) (Type, Print) Tipell <u> 7835</u> 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician n D M Joan Katherine Merica MAY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bel Air If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 0 2 00 148 Day 936 Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 □ M 2 🔯 F 74 357-28-2500 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Bel Air MD Harford 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21015 USA 509 Flintlock Drive 2 should be filed within 72 hours after death v n and Mental Hygiene. Is marked other than "natural" مه نامهم عام Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: White 21215-0036 \$ 3 Nidowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Katherine (unknown) John Nielsen 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bel Air, MD 21015 Pages 1 and 2 of Health a 509 Flintlock Dr. Charles R. Merica Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition = 5 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once. 05-12-2010 Baltimore, MD Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CEREBROVASCULAR disease or condition resulting in death) - /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-tran P.O. Box 68760, resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 No Certification: To this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred or Attending 1 Natural To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fun 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier allegan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0

DHMH 17 Rev 1/2001

State Registrar 622 S. UNION AVE

DHANJANI

31. Date filed (Month, Day, Year)

MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Donald Forrest Merritt May 2010 1:16 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bel Air Harford Upper Chesapeake Medical Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Pennsylvania 8. Date of Birth Funeral (Month, Day, 1 🗆 M 2 🗆 F Hours Director 179-32-0604 Dec. : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatin event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2001 Beech Street 21015 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No If Yes, Give Year or Dates. 11, Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by 1 Yes 2X No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Chief Scientist U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) rmit. Page 1 and 2 should be partment of Health and Memportant: If item 27 is marke y mjury or other traumatia Harold Forrest Merritt Dorothy (nmn) Nickle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Merritt / Wife 3126 Tipton Way, Abingdon, Maryland, 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 5/10/2010 Towson, Maryland permit.
Depertminertraining in the property and in the property and in the property and in the property in the 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eachine Immediate Cause (Final Onset and Death Physician, tatic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). attending physician and Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year 1 Yes 2 L 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: The law requires 2 No 3 ☐ Probably 4 ☐ Unknown Records, Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has malignan. Be 25. Was case referred to medi 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: Certificate: To 1 Hanpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined 24 hours Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PLUMTREE RD, BEL ADR MU JOSEPH ANGELO, Suik D 208 31. Date filed (Month, Day, Year, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Barbara West McLaine $M_{ay}^{Month}6, 2010$ 8:29 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 11503 Parkedge Drive Rockville Montgomery 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 579-48-**5303** 1 □ M 2 🕱 F Months Days Hours Min. March Day, 1930 80 lashThgton, D.C. **Director** Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Rockville Maryland Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 11503 Parkedge Drive United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🛛 No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) the Homemaker Own Home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any liviry or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martin Raymond West, Sr. Agnes Jesse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13114 Collingwood Terrace, Silver Spring, Maryland 20904 Margaret Arnett/Daughter 20b. Place of Disposition (Name of Montgomer ty Crematory or other place)
Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State 1 D Burial 2 X Cremation 3 D Removal from State 2010 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Page Name and Address of Facility Robert A. Bethesda-Chevy Chase Bethesda, Maryland 20814. Signature of Funeral Service Licenses Pumphrey Funeral Home/ 7557 Wisconsin Avenue M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Chronic Death Physician/ disease or condition resulting in death) Lung Cancer) Medical Due to (or as a consequence of) Examiner Chronic Bladder Cancer Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of). Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director After this certificate has been simple but the death. attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? tor: After this certificate has been signed by the atte the funeral director, page 2 should be detached for Month 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2X No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🔀 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural 5 Pending injury 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical 29a, Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of d 29c. License number 29d. Date signed (Month, Day, Year) D53177 May 6, 2010 MI 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9707 Medical Center Drive #300, Rockville, Maryland 20850 John Wallmark, M.D.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Register's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM# / per FH, G904, 6 / 16 / 2010, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 3, Physician/ 2010 Thomas McCarthy AKA Florence Thomas McCarthy 9:49 РМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye November 29 . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 👿 M 2 🗆 F Months Davs Hours Min 1926 Massachusetts 027-16-3705 86 83 Yrs Director Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10d. Inside City Limits the Maryland 10c. City, Town or Location Director 1 ☐ Yes 2 X No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code ö 10a, Citizen of What Country? ms 23a or must be n Funeral with 1 7925 Ivymont Terrace 20854 United States items 2 permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Evaminar mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 Tes 2 No Specify: r Yes, Give Year or Dates 1945–1986 Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Policy Administration U. S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John McCarthy Nora McCarthy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 531 Main Street #511, New York, New York 10044 Mary C. McCarthy/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State August cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 24, 2010 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery Arlington, Virginia 21. Signature of Funeral Service Licence Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850 Haron nai M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death a aiterioscleratic cordiovasculas disease Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a config. Lience of cause. Enter Underlying Cause (Disease or iinjury use as the burial-tran that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of) Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be epsilons after death. Funeral Director: After this certificate has been signed by the attending physicia IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day ☐ Pregnant ☐ Unknown 5 Other (specify) Pregnant at time of death 1 | Yes 2 L 9 | Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Hinknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has b autopsy performed? this certificate 2 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 70 Vital the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After injury 1 Natural 5 Pending Division 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Prysidant. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) \$600 Old beorge town, Yevgeniy Gincheryan, M.D. Bellesda, M.D. 20 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

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McCarthy

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ital Medical Evaring Interest any outless a group. Baltimore, Maryland 21215-0036

For State Registrar

Physician

/Medical

Examiner

Funeral Director

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760, \hookrightarrow

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

		PRINKET REGIONING	1705	1011	UVEL		ININCE	thplace (State or Foreign						
ral tor		5. Social Security Number 220-60-1814 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)												
		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location												
1	_	10a. State 10b. County		10d. Inside City Limits										
	Director	MD Montgomery	Burton	nsville				1∏Yes 2☐No						
	ire	10e. Street and Number		10f. Zip Code		10g. 0	Citizen of What Co	ountry?						
	<u></u>	16114 Columbia Pike		20866		U.	S.A.							
	Funeral	11. Marital Status 12. Was Decede Armed Force	nt Ever in U.S.	13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Spe	cify Yes or No-	14. Race - Ame Black, White							
		1 Never Married 2 Married 1 ☐ Yes 2 If Yes, Give	ΩMo	1 □ Yes 2 □ X X X		ilouri, etc./	Specify: Wh							
	d by	3 ☐ Widowed 4 ☐ Divorced Year or Date	s:	100 200	Specify: W11	Secily. WILL CC								
	ete	15. Decedent's Education (Specify only highest grade completed)	16a.	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of workin	6b. Kind of Business/Industry								
	Completed	Elementary/Secondary (0-12) College (1-40 Grade 10)r 5+)	iife. DO NOT use retire rick Layer	ed)	Masonry								
		17. Father's Name (First, Middle, Last)		LICK Dayer	18 Mother's Name									
	Be	17. Father's Name (First, Middle, Last) Walter Nicholson 18. Mother's Name (First, Middle, Maiden Surname) Mary Wilkerson												
	၉	19a. Informant's Name/Relationship (Type. Print)	10h	Mailing Address (Stree	d		ar Tawn State	un Stato Zin Cado)						
		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Mary Jane Wilkerson / mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 16114 Columbia Pike Burtonsville, MD												
		20a. Method of Disposition	20b. Place of	Disposition (Name of	Da		Location - City or							
	ı	1 🗹 Burial 2 ☐ Cremation 3 ☐ Removal from Sta	te cemeter	y, crematory or other pla wrdige Mem	ice)		Oorsey, Maryland							
aj.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Meadow					aryland						
ouce			100770	Donaldso.	ess of Facility n Funeral 1 ott Avenue	Home, P.A Laurel,	Marylan	d 20707						
		23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	sed the death. Do n	not enter the mode of dy	ing, such as cardiac o	r respiratory arrest,		Approximate Interval Between						
an		Immediate Ceuse (Final disease or condition and CAPDIORES PRACRY ARREST												
at		resulting in death) Due to (or as a consequence of):												
er		Sequentially list conditions, b. MOCARDIAL INFARESCEN												
-	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	as a consequence o	of):										
Î	каш	Cause (Disease or Injury that initiated events c. Due to (or as a consequence of):												
	by Physician/Medical Examine	2 do to for as a consequence off.												
	edic	d.												
	Z	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcomes 23c. I	23d. Date of de	livery										
	icia	1 Vos 2 No. 4 Pregnar	h 2 Fetal death It at time of death	3 ☐ Ectopic pregnan 5 ☐ Other (specify) _			Month							
	hys	9 Unknown 9 Unknow												
	۶ ۲	Part II. Other significant conditions contributing to deat		e to the cause of death?										
	당	1 _Yes 2 _No 3 _												
	Complet					24a. Was an autopsy	24b. Were at	utopsy findings available completion of cause of						
,	E O					performed?	death?							
	BeC	25. Was case referred to medical			26. Place of Death									
		examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inp	atient 2 ER/Out	tpatient 3 DOA Ot	her:	ne 5 Residence	6 ☐ Other (Spe	ecify)						
	٦	27. Manner of Death 1 ☑ Natural 5 ☑ Pending (Month,		ime of 28c. Injury Wo	iry at 2	8d. Describe how in	ury occurred							
	atic	2 Accident investigation	24), (34.)		Yes 2 □ No									
	ertific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of building,	Injury - At home, far etc. <i>(Specify)</i>	rm, street, factory, office	2	8f. Location (Street City or Town, Sta		ural Route Number,						
	Medical Certification: To	29a. Certifier (Check only one) 1 Certifying Physician: To the be 2 Medical Examiner: On the basi and manner	s of examination and	e, death occurred at the d/or investigation, in my	time, date and place, a opinion, death occurre	and due to the cause ed at the time, date a	(s) and manner a and place, and due	s stated. e to the cause(s)						
	₹ S	29b. Signature and title of certifier	1	29c. Licen	se number	29d. [Date signed (Mont	th, Day, Year)						
		DODICEAD DIDIONES												
	}	30. Name and address of person who completed cause of	of death (Item 23a) (Type, Print)			-1001							
		LOCET OLA	OE.	LAURI	The REG	TIONAL	1/25	SPITAL						
Stat		31. Date filed (Mon Say Year) 2010 32/Heg	strar's Signatur	ho a. N.										

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05º07-20P® 730 P Marlene Ann Nickel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harford Abingdon 3110 Eden Drive Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2 💢 F 65 Months Hours 11 - 0 4 - 194 4 Country) MD **Director** 215-42-9507 Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10d. Inside City Limits Director 1 Yes 2X No MD Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21009 USA 3110 Eden Drive death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Yes 2 X No Yes, Give þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerical Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Margaret Hitchcock Herman Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Abingdon, MD 21009 3110 Eden Drive Harry C. Nickel (Husband) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Bayview Crematory 5-11-2010 Baltimore, MD Signature of Functor Service Licenses 22. Name and Address of Facility Schimunek Funeral Home of Bel Air MacPhail Rd BelAir, MD 21014 610 W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Mas Medical resulting in death) Due to (or as a couse ty nce of) Examiner Sequentially list conditions, Exis to (or as a non) if any leading to immedia cause. Enter Underlying Cause (Disease or linjury Exami sician and burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Pregnant at time of death 2 🗆 No Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 1 🗌 Yes 2 No 25. Was case referred to predical Be 26. Place of Death (Check only one) Other: မ 1 🗆 Yes 2 **N**0 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Mann of Death 28b. Time of 28a. Date of injury 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funeral (Month, Day, Year) ✓ Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide
4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ZV TO 127250M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** en ISTYN Anne If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian þ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Completed and Mental Hygiene. s marked other than "natural numatic event, the Medical E Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, WILLIAM 19a. Informant's Name/Relationship (Type, Print) DIAUGIA FER. 19b. Mailing Address (Street and Number or 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a, Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final 2984 Pnysician disease or condition resulting in death) Medical Due to (or as onsequence of Examiner Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant 5 Other (specify) Pregnant at time of death Yes 2 No io une runeral ulrector. Atter this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? P 1 Denpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Accident 5 Pending 1 ☐ Yes 2 ☐ No 2 Accider
3 Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) d title of certifier 29b. Signature Name and address of p O

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ O Car O Month 11-00 + Medical MARY CECELIA PFEIFER 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SAGIMORE WASHINGTON MEDICAL AGINE CHEN B NTE 12rui6 HELINDE 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Funeral . Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) Months Days 1 □ M 2 🗓 F FEB. 8, Year) Hours Director 217.34.9404 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits 1 Yes 2 XXNo MD ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14 PROCTOR AVE 21061 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2XX No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Black, White, etc. Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4XX Divorced Specify. WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) MANAGER CAFETERIA A.A.Co. SCHOOLS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM JOSEPH BEECHER MARY CECELIA ROULE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 403 VERNON CT., MARGARET ANN TORMOLLAN SISTER GLEN BURNIE, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 KXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Sg GLEN HAVEN CEM. MAY 15, 2010 GLEN BURNIE, MD 22. Name and Address of Facility
FINK FUNERAL HOME, P.A. ur of Funeral Servic GRE COR M01148 426 CRAIN HWY. S., GLEN BURNIE, MD 21061 Enter the or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock ne cause on each line Interval Between Immediate Cause (Fina Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner EAR MBETE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed Yes 2 death? 1 Yes 2 🗌 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 2 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Man of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide etermined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated, (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practionar: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3V 32 Name and address of person who complete leted cause of death (Item 23a) (Type, Print) 20161 31. Date filed (Month, D. Year) **MAY 1 2 2010** 32. Registrar's Fignature State

DHMH 17 Rev 7/2009

Registrar

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urs after	3 Widowed	ried 2 Married 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	er in U.S.	13. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☐ No		pecify Yes or No- o Rican, etc.)	14. Race - An Black, Wi Specify: B	nerican Indian, hite, etc. ACK
ygiene "natura ner than "natura t, the Medical	(Spec	15. Decedent's E cify only highest gro ondary (0-12)		(0	ecedent's Usual Occu live kind of work done e. DO NOT use retire Oil Tan	during most of wor	king	Best En	signoustry livonmental
ba fill High Hold off	17. Father's Name	(First, Middle, Last	er Sr.				ne (First, Middle, M Dovsey	aiden Sumame)	VICES
2 a a a		ame/Relationship (Type, Print) Wife	19b. M	ailing Address (Street	and Number by Ru	Ave. B	City of Town, State	Zip Code) 21213 Maryland
permit. Pagas 1 and Department of Health Important: If Itam 27 any Injury or other tr 2068.			☐Removal from State	20b. Place of Dicemetery, MH. Zi	sposition (Name of crematory or other pla	ter 51	Date 2	oc. Location - City and sdow	or Town, State re, Marylan
permit. Pa Departmer Important: any Injury once.	21. Signature of Ft	uneral Service Lice	Parker	/	22. Name and Address 3512 FM	ess of Facility Par Lenck	Ker Fur Ave B	reral Ho altimore	Maryland
Physician /Medical	23a. Part1. Enter t shock, or hea Immediate Cause disease or condition resulting in death)	ırt failure. List only (Finaf	nplications that caused the one cause on each line. a	Heros	enter the mode of dy	ng, such as cardiac	or respiratory arre	st. Difease	Approximate Interval Between Onset and Death
Examiner and Intransit	Sequentiafly list co if any, leading to in cause. Enter Unde Cause (Disease or	nmediate erlying injury	b. Due to (or as a c	typer.	fension	/			Years
		ast	Due to (or as a c	onsequence of):					
ng Physician: The law requires that the death certificate be a liter this certificate has baen signed by the attending physician neral director, page 2 should be detached for use as the burian. To Be Completed by Physician/Medical E	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2(9 Unknown	months?	23c. If yes, outcome of 1 ☐ Live birth 2 (4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	у		23d. Date of d Month	lelivery Day Year
en signed bould be deta	Part II. Other sight	icant conditions	contributing to death but on Obs Fruct		e underlying cause gr	ven in Part I.			to the cause of death? Probably 4 Donknown
ng Physician: The law requir tier this certificate has baen s ineral director, page 2 should on: To Be Completed	1	ros take	Camer				24a. Was an autopsy perform	ed? death	autopsy findings available o completion of cause of es 2 🖺 No
sician: s certifica lirector, p	25. Was case refer examiner?		Hospitaf:	2		205	th (Check only one)	
ng Physi ifter this c ineral dir.			1 ☐ Inpatient 28a. Date of Injury (Month, Day Y	2 ER/Outpa 28b. Tim ear)	e of 28c. Inju	4 🗆 Idui sili g H	ome 5 Resider 28d. Describe hov	nce 6 Other (Sp v injury occurred	ecity)

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fune

HATKET, MG|CO|M

investigation 1 ☐ Yes 2 ☐ No

2 Accident
3 Suicide
4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

no completed cause of death (Item 23a) (Type, Print)

State Registrar

Medical Certificati

29b. Signature and title of certifier

XEVIN It. Scruggs MM)
31. Date filed (Month, Day, Year)
MAY 12 2010 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 20b perFH, G903 5/18/2010 WS
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PM Medical 4a. Facility Name (if not institution, give s 4b. City, Town, or Location of Death Examiner 4c. County of Death Dul Imore If Under 1 Year If Under 24 Hrs. 8 Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign **Funeral** 6-400 1 X M 2 🗆 F Days Hours Min. (Month, Day, Ye Director MARYLANI Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director permit. Page 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f si any injury or other traumatic event, the Medical Examiner must be notified. 1 Yes 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Be Completed by 1 Never Married 2 Married 1 Yes 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) eaning 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) 은 19a. Informant's Name/Relationship (Type, Print) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ITD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 117 ate 🗴 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Ficility 21. Signature of Funeral Service Licensee nergi 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) MUNCON Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to (or se a consequence or) certificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) Unknown 1 Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed? 2 No 1 Yes 2 4 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No မ 1 🖪 Inpatient 2 🗆 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrac's Signature State Registrar

DHMH 17 Rev 7/2009

Thomas

James

3

DHMH 17 Rev 7/2009

State

Registrar

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LINTHICUM

31. Date filed (Month, Day, Year)

MAY 12 2010

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10-03514 Henry Reinisch

10-03514 Henry Reinisch		Please Type or Print in Black Indelible Ink. Ensure All Copie State of Maryland / Department of Health and Mental H 1- For State Registrar Certificate of Death									giene	ygiene 2010 147				
Physici Medical Exam		Decedent's Name (First, Midd	, ,	nry		Re	inisch			2. Date of Death Month Day May 6, 2010				3. Time of Death 1343 hrs		
		4a. Facility Name (if not institution Franklin Square Hosp		imber)		4b. City, Tov Roseda		ocation of				c. County of Baltimore		ntv	
Funeral Director		5. Social Security Number 213-68-7768	6. Sex	7. Ag	e (In yrs. last birth	day)	If Under	1 Year Days	If Under Hours	24Hrs. Min.	Fore			Foreign		
any		Usual Residence of Decedent 10a. State 10b. County			10c. City, Town o								,+,,,,,		10d. Inside City Limits	
*	tor	MD E		Middle Riv									1 Yes 2 No			
h the Mar 3a or 28s	Director	10e. Street and Number 808 Wilson	808 Wilson Point Road Apt. C					10f. Zíp Code 21220					10g. Citizen of What Co United St			
s, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Montal Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f shorrammatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 Never Married 2 M 3 Widowed 4 Div	Ever in U.S. . No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)							14. Race - American Indian, Black, White, etc. Specify: White					
215-0036 be filed within 72 hours af ntal Hygiene. rked other than "natural ent, the Medical Examin	Completed by	15. Decedent's Education (Spe Elementary/Secondary (0-12)	College (1	-4 or	di	ıring m	nt's Usual Oc nost of workin	ife. D				16b.	Kind of Busin			
21215-0036 vuld be filed within 7 Mental Hygiene. marked other than	e Com	12 Years 17. Father's Name (First, Middle	Last) 2 Yea	rs_		P	araleg		.Mother's	Name (F	irst, Middle	, Maide	Lav n Surname)	√		
D 2121 should be t and Mental is marked	To Be	Carroll G. 19a. Informant's Name/Relations	hip (Type, Print)						and Numb	er or Rui					Zip Code) 21220	
5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Mrs. Anita M. 20a. Method of Disposition 1 Burial 2 X Cremation			20b. Place of	Dispos					Apt. Date		Location - C		rer, MD own, State	
Baltimore, permit. Pages 1 a Department of He Important: If ite		4 Donation 5 Other Si 21. Signature of Funeral Service	pecify:			22. N	Servic	dress o	f Facility		11/20	_	Towsonda1k.	<u> </u>		
ய கத்தத் Physician	_	23a. Part I. Enter the disease, or	complications that co	aused	the death. Do not	79	922 Wi	se A	Ave	Dung	dalk,	Mar	yland	21	222 Approximate Interval	
/Medical Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	A 15 1		Cardiovascula	r Dis	ease							_	Between Onset and Death	
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):														
Scuted and transit	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	conse	quence of):									-4		
š 5 -	dical	UNPENDED	AMENDED			_										
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	UNPENDED AMENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23d. Date of death Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23d. Date of death Month										livery Da	y Year				
, P.O. trees that the signed by be detached		Part II. Other significant conditions Chronic obstructive p			but not resulting in	n the u	inderlying ca	use give	en in Part	l.		_	use contribu		e cause of death?	
Division of Vital Records, P.O is or Attending Physician: The law requires that the safter death. al Director: After this certificate has been signed by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted.	Completed by									_			prio dea	r to cor	osy findings available inpletion of cause of	
ital Recision: The section page	BeC	25. Was case referred to medical examiner?	100						Death (Cl		y one)				2 NO	
ion of Vii tending Physic eath. tor: After this the funeral dir	<u>ات</u>	1 Yes 2 No 27. Manner of Death	28a. Date of (Month,	·	nt 2 🗸 ER/Outp				at Work?		d. Describe	,	ury occurred	Other:		
Vision or Attendi fter death. Director: in by the f	ertification:		ing tigation		ury - At home, farm	n, stree			i 2 No				and Number o	r Rural	Route Number, City	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	아	4 Homicide deter	mined (Specify)	of my	knowledge, death	occur	red at the tim	e, date	and place	, and du	or Town, s		nd manner as	stated.		
Fo the within To the comple	Medical		2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
		Calur	M	/	4	5		.C.M.					y 7, 2010			
wx1		30. Name and address of person Zabiullah Ali, M.D.	Assistant Medica	al Ex	aminer 111	Peni	n Street, E	Baltim	ore, MD	2120	1					
St Regist	ate rar	31. Date filed (Month, Day Year)	32. Reg	gistrar	s Signature	(m)	9									
													OCWF.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ M05/08/2010 5:29 A M Frank Robert Rutkowski, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Carroll Hospice - Dove House Carrol1 Westminster 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 🖾 M 2 🗆 F Days Hours Country) (Month, Day, Year) 10/11/1941 68 Director 217-40-6693 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Carrol1 MD 1 Yes 2X No Westminster 10e, Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1611 Valley Dr USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ò þ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 'natural", Specify: Completed 3 Divorced 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 Draftsman Dance Brothers other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Frank Rutkowski Dorothy Lomar and 2 should to Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 Patricia Rutkowski/Wife 1611 Valley Dr., Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State injury or Carroll Crematory 5 1/2-/8 Donation 5 Other (Specify) Winfield, MD ure of Funeral Service Lice Burrier Queen Funeral Home & Crematory, P.A. any alun 1212 W. Old Liberty Rd., Winfield, MD 21784 Part 1 Enter the disease, or complications shock or heart failure. List only one cause hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Interval Between Onset and Death Immediate ause (Final di ease or ondition res liting in death) Physician/ 89/5 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of): and I-transit Exami that the death certificate be executed resulting in death) Last Due to (or as a consequence of): burial-Physician/Medical the SB IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death ed by the a detached t 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Tyes the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Practioner: To the best of my knowledge galimile) and the marian stat 29b. Signature and title of certifier MA 00058137

101

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

of Vital

Division

State Registrar

DHMH 17 Rev 7/2009

St 307 Westminste

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 2000 03:57 AM lay Datie Bridgeforth Russell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Roland Park Place Baltimore 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖫 F Yrs Director 98 <u>237-14-2818</u> 04 08 AL Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director ¹¥ Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2111 Liberty Heights Ave
11. Marital Status 12: Was Decedent Ever in U.S.
Armed Forces? hours after death U.S.A.

14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes No Specify: Specify: Black 3 Widowed 4 ☐ Divorced Completed ifiled within 72 h I Hygiene. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 4yrs+ Employment Counselor State of Maryland permit. Pages 1 and 2 should be filed Department of Health and Mental Hygin Important: If Item 27 is marked other any Injury or other traumatic event, til 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Bridgeforth Datie Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u> Hattie Russell-Daughter</u> 2111 Liberty Heights Ave, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arbutus Memorial 5/14/09 Arbutus, Md 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21215 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Awan Ced Whertselerstic Cardiavanewlarr I nom pour Approximate Interval Between Onset and Death Indvanced atherseleratic carolisvascular disease **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner certificate be executed and burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical the as attending IF FEMALE: esn 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 ☐ Ectopic pregnancy for Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9□Unknown 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Veripheral hascular disease with gas 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed Dementia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy certificate } perform Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Wursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral c 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 V latural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) greger my /ae ▶ 7 Kabelle D13657 May 6,2010

State

Registrar
DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
NIBABELLE The GREGOR, 720 W 40 % STREET, BALTIMORE, 570 21211

32. Registrar' Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	arylan		artment o			and M		giene /	2010	14776	ĵ
	Physicia	ın/	1. Decedent's Name (First, Middle, Sarah Ride								2. Date of De	Day	Year	3. Time of Death	_
	Medic Examir		4a. Facility Name (if not institution,				4b. City, Tov	vn. or	Location o	f Death	4 29 2010 4c. County of Dea				_
Н			Ivy Hall Geriat	Balt						ltimo					
	Funeral		5. Social Security Number		e (In yrs. la	ast birthday) Yrs.	If Under 1		If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Da 02/05/	:h	9. Bir	thplace (State or Foreign	1
10	Director		218-36-2691 Usual Residence of Decedent		72_	118.					02/05/	/1938	lPen	nsýlvania_	
	land shov dat	후	10a. State 10b. County			_			10d. Inside City Limits						
	Mary 28a-f otifie	Director	MD Harfo	rd	Fa	11ston								1 🗆 Yes 2 🛣 No	5
	th the		10e. Street and Number				10f. Zip Co					10g. Citize	en of What C	ountry?	
	ith wii ms 2 musi	Funeral	1904 Parkvue Ro			2 40.1	210			:- D (O		U.S.			_
(0	er dea or ite niner	by Ft	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Decedent E Armed Forces? 1 Yes 2 🔀		s. 13. V	Yes, specify	Cuban	n, Mexican,	Puerto F	cify Yes or No- Rican, etc.)	14	 Race - Ame Black, Whit 		
03	rs afte iral", Exar	ed b	3 Widowed 4 K Divorced	140	1	☐ Yes 2 🔀	No	Specify:		Specify:			hite		
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d 2	led wi Hygie other ent, ti	Be (17. Father's Name (First, Middle, La	2		Cerc	IIIea I	NUL			istant (First, Middle,		lthcar	<u>e</u>	_
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show with injury or other traumatic event, the Medical Examiner must be notified at once.	မ	Louis F.	Whetzle	r			-	Haze	_	L.	maio on oa	Good	rich	
lary	should and N is ma		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	g Address (St	reet ar	nd Number	or Rural	Route Number	r, City or To	own, State, Zi	p Code)	
≥.	nd 2 sealth m 27 ner tra		Deborah Kegley	/ Daughter		1904	Parkv	ue	Rd, F	alls	ston, M	D 210	147		
Baltimore,	ge 1a nt of H : If ite or ott		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State			sition (Name c natory or other)	D	ate	20c. Loca	ation - City or	Town, State	
Ħ	it. Par intmer intant injury	1	4 🖾 Donation 5 🗆 Other (Sp.		Ana		fts Regi							Maryland	_
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	Physician/	0 7	shock, or heart failure. List onl Immediate Cause (Final disease or condition	y one cause on each line		ncer								Interval Between Onset and Death	
	Medical Examiner		resulting in death)	a. Due to (or as a											
		-E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
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876	tificat ng ph	Med	IF FEMALE:							_					Ξ
Box 687	th cer ttendii or use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 🗌 Feta	death 3	Ectopic preg					23	23d. Date of delivery Month Day Year		
B.	r the a	Physician/Med	1 ☐ Yes 2 🗹 No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of d	leath 5∟	Other (specif	y)					WOITH	Day Year	
Division of Vital Records, P.O.	that the	by Ph	Part II. Other significant conditions	s contributing to death b	ut not resu	ulting in the u	nderlying caus	e give	n in Part I.		23e. Did to	bacco use	contribute to	the cause of death?	
JS,	uires in sign	ed p									1 🗆 1	/es 2 □	No 3□P	robably 4 Unknown	1
Sor	w required as bee	plet									24a. Was a		24b. Were au	topsy findings available completion of cause of	_
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tal	ician; sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				6. Plac	ce of Death						
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2	ital or ars aft ral Dir										City or Tow				
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 L Medical Exa	hysician: To the best of a miner: On the basis of ex	amination	and/or investi	gation, in my c	pinion,	, death occ	urred at t	he time, date ar	nd place, ar	nd due to the	cause(s) and manner state	d.
	To the vithin To the comple	Σ	only one) 3 ☐ Certifying N 29b. Signature and title of certifier	urse Practioner: To the I	oest of my	knowledge, d	29c. Lic			ind place			nd manner as signed (Monti		_
			► MS Rij	apalmeM.D.				İ	D005	74			16/1		
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	Cl-v		30. Name and address of person who November 2010 and 31. Date filed (Month, Day, Year)	JAPARSE, MID	r's Signatu	255	(1)[][]	10-	درد،	_					_
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 30PM v ma doic Medical Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 710057 Social Security Number 7. Age (In yrs. last birthday, If Under If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 M 2 - F Months Days Min. Year 716-28-**Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1208 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Seconday (0-12) College (1-4 or 5+) Elementar Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematery or other place) 4 Donation 5 Other (Specify of Funeral Service 4000 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cau on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ O LNIDA. 00 disease or condition 4 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, the any leading to him collate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a nonsequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death 2 No ed by the a detached f 9 Unknown 9 ☐ Unknown signed by Part II. <mark>Other significant conditions</mark> cont<u>r</u>ibuting to death but not resulting in the underlying cauşe given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 1 ☐ Yes 2 ☐ Wer 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an s certificate has blirector, page 2 s performed? 2 🗌 No Yes 2√ 1 Tyes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: Certificate: To 1 🗌 Yes 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred eral Director: After if filled in by the funera 1 Natural 5 Pending work Accident 1 🗌 Yes 2 🗌 No Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d

To the Funeral Direct
completed filled in by determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of persor 000 31. Date filed (Month, Day, Year) 32. Regierar's Signature State

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗸 U Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** STONE OHN PM 2010 835 MAX 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HUPKING BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) October 26,1940 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**√**2 M 2□ F Months 218-36-7060 69 Virginia Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f sho 1 □Yes 2 □ No Directo Maryland Baltimore Overlea 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3 McCormick Avenue 21206 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ∐Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White ₽ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, ITE M College (1-4or 5+) 8 years Bricklayer Masonary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alfonso Stone Elleta Quillen ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 McCormick Avenue, Overlea, Maryland 21206 Blanche Stone wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Cardens of Faith Cemetery May 14,2010 4 Donation 5 □Other (Specify) Rosedale, Maryland Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. Signature of Fyneral Service Licens Do not enter the mode of dying, such as cardiac or respiratory arrest, complications that caused the death. only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, of shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) ARRYTHMIA **Physician** 45 minutes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) I □Yes 2 □No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 □ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **1** No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation nours after death neral Director: / filled in by the fo 2 Accident 3 Suicide 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, Vintero MD KFS-000 10,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN AVENUE BALTIMORE MD CHRISSLUI 4940 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month May Day 2 2 Year John J. Sweeney, Jr. 4:15P Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death imore Saint Joseph Medical Center 5. Social Security Numbe 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days 1 XXM 2 - F Months Hours Min 216-16-1121 85 1277971924 MaryPand **Director** Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Timonium 1 Yes 2 KNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2525 Pot Spring Road Unit K408 21093 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. I Hygiene. other than "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Attorney Legal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked of John J. Sweeney, Sr. Edna Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 permit. Page 1 and 2 she Department of Health an Important: If item 27 is Mary Rosewin Sweeney / Wife 2525 Pot Spring Road Unit K408 Timonium, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State any injury or 5/14/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) Mary's Govans Cem 21. Signature of Funeral Service Dicense 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 6 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ SHOCK disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 10 DAYS PERITONITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that the death certificate be executed burial-transit 10 DAYS FAILURE RENAL that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 1 Yes 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ည 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 X Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu 2 No ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) MAY 2010 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day, Year)

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature Knewa

DSLER DRIVE

TOWSON,

MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month JOAN M. SUSEMIHL 2010 5:25A ^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE TOWSON GILCHRIST CENTER Social Security Number . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. Month, Day, Year) Nov.15,1935 74 Director 212~32~0213 Maryland Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Directo Baltimore County Maryland Baltimore 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21237 USA 1513 National Rd. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 200 Married þ Baltimore, Maryland 21215-0036 White If Yes Give 1 ☐ Yes 2 🔀 No Specify: "natural", Specify: 3 Divorced 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 10 yrs. Bookkeeper Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Johnston Gladys DAley 19a. Informant's Name/Relationship (Type, Print) (Step --19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3420 Kreitler Rd. Forest Hill, Md. 21050 Loretta S. Burghauser Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date XX Burial 2 Cremation 3 Removal from State Gardens of Faith 4 Donation 5 Other (Specify) 5~11~2010 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7401 Belair Rd. Lassahn Funeral Home Baltimore. Md 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician CMPLICATIONS disease or condition resulting in death) Lowth Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been been also as a continuous process. Cause (Disease or iinjury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? jo Month Year 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 🞾 No 유 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) (10 S) Le 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 A Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending nours after death.

neral Director: After tilled in by the fun 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my policy. Medical 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Curarles W NE 0 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 201 Joan Eleanor Stunz 10:30 AM May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4 Salix Court Middle River Baltimore Co. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Days Hours (Month, Day, 216-30-0671 75 **Director** 9.1935 Usual Residence of Decedent "natural", or items 23a or 28a-f show adical Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🖾 No MD Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral should be filed within 72 hours after death with i and Mental Hygiene. 4 Salix Court 21220 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify. Completed 3 Widowed 4 Divorced Year or Dates White event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Steel Industry 12 Years Steelworker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Carey Pollock Sarah Rice or other traumatic 19a. Informant's Name/Relationship (Type, Print) Brother Taw in 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra Mr. Wayne R. Michael, 3318 Fait Ave. Baltimore, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Towson, Maryland Hilltop Service Corp. 5/12/2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Wise Ave. Dundalk. art 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final nterval Between Onset and Death Ph_sician/ disease or condition resulting in death) ear Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or): Examir physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 attending p as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Unknown the 9 Unknown been signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 the Hospital or Attending Physician: The law requires Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has page 2 s autopsy performed? Yes 2 X No certificate 2 🗀 No 1 Yes 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 1 🗌 Yes 2 XNo ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA After this 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 1 Alatural 5 Pending work? 1 ☐ Yes 2 ☐ No thin 24 hours after death.

the Funeral Director: A mpleted filled in by the fu Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1. 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 the within To the 29b. Signature and title q 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAVITHA 1124 ~ male 31. Date filed (Month, Day, Year 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** NOID /Medical 4c. County of Death Examiner KAITIMO N/A lf Under 1 Year Birthplace (State or Foreign Duntry) 8. Date of Birth **Funeral** Days 5/10/1948 145xM 2□ F 62 217-50-2073 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Funeral Director MD Carroll Sykesville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21784 United States 6597 Streamwood Ct. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11 Marital Status Black, White, etc. **KX**Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married XX Married White 1 ☐ Yes 🏋 No Specify. Specify: þ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 t h College (1-4or 5+) Sales Power Lighting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Loretta Josephine Schmauss Nickols Austin Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6597 Streamwood Ct. Sykesville, MD 21784 Gwendolyn J. Smith (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Carroll Crematory 5/11/2010 Winfield. MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee Burrier-Queen Funeral Home and Crematory, P.A. TooklA Kellen. 212 W. Old Liberty Rd. Winfield, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ue (or a a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ▼No 24a. Was an 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No 27. Manner of Death Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 inpatient 3□ DOA 2 ER/Outpatient Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othnany Injury or other traumatic event

death with the Maryland

filed within 72 hours after

Saltimore, Maryland 21215-0036

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

burial-trar physician as use for signed to be detail page 2 s certificate has

funeral director,

Physician: The law requires that the death certificate be executed After this or Attending within 24 hours after death.

To the Funeral Director: filled in by Hospital completely

Division or Vital Records, P.O. Box 68760,

Registrar

Medical

31. Date filed (Month, Day, Year)

4 Homicide

29b. Signature and title of certifie

29a. Certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALEXIS D.SMITH, MD 22 SOUTH GREENEST BATIMSES MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) **Physician** Blanche /Medical 4a Facility Name (If not institution, give street and numb Examiner 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign Funeral Davs Months 1 M 2 B Director Usual Residence of Decedent permit. Pagas 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Health and Mantal Hygiena. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 DYes 2 □ No Completed by Funeral Director 10g. Citizen of What Count Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Neyer Married 2 ☐ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry econdary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be Lucille Mannina Known daughter 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Appromate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) ATHEROSCUERATIC CARDIOVASCULAR DISEASE /Medical YEARS Examiner Due to (or as a consequence of Medical Certification: To Be Completed by Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death cartificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown oral Director: Aftar this cartificata has bean signifilad in by the funaral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 SHC 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 ☐ No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, efc. (Specify) 4 Homicide within 24 hours a

To the Funeral C

complataly filled 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature d eddress of person who completed cause of death (Item 23e) (Type, Print) KELBRIDE RD, BACTIMORE MAD 21236 State

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#5perFH.G904,6/11/2010, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2050 WARREN THOMPSON Ma 4 2010 in Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death Hospital Raetimone Sinai of Baltimore Age (In yrs. last birthday) 1 Year If Under 24 Hrs. cial Security Number 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Ye 26–1924 1X M 2 Months Days Hours Min. Director MD Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director MD BALTIMORE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3412 PARKINGTON AVENUE 21215 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black White etc 1 Never Married 2 Married þ filed within 72 hours after Maryland 21215-0036 BLACK If Yes Give 1 Yes 2 No Specify. Specify 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) MAINTENANCE permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other than injury or other traumatic event, the once. GREATER BALTIMORE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ CLIFTON THOMPSON IDA WARREN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLADYS BARTEE/DEPENDENT FRIEND 3412 PARKINGTON AVENUE, BALTO., MD 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Penation 5 □ Other (Specify) WOODLAWN CEM. 5/17/2010 BALTIMORE, MD 21. Sign ture of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST., BALTO., MD. 23a. Parid. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician, disease or condition resulting in death) lenge Due to (or as a consequence of): Medical Examiner Kidney Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): hypercalcem ending physician and use as the burial-trans that initiated events resulting in death) Last (or as a consequence of) Physician/Medical severe Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Other (specify) Month Day Year Pregnant at time of death 4 Pregnant 9 Unknown 1 Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician: The law autopsy perform this certificate 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Hospital: Other: 1 🗌 Yes 2 No ည 1

✓ Inpatient 2

ER/Outpatient 3

DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Deatl 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work?
1 Yes 2 Accident
3 Suicide
4 Homicide 2 🗆 No Investigation Director: filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 63282 May 2010 who completed cause of death (Item 23a) (Type, Print) Sinai Hospital 2401 W. Belvedere Avenue Baltimore of Raltmore

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) **NAY 12 2010**

Worren

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 2010 11:52A M Ronald Thompson May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NA Baltimore Alice Manor Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F 08-30-4 Country) unk. 219-40-3351 67 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits 72 hours after death with the Maryland Director XXYes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 2095 Rockrose Avenue 21211 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: American "natural", 3 - Widowed 4 - Divorced Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natur lury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade NA Truck Driver Company Be 17. Father's Name (First, Middle, Last) unk. Maryland 18. Mother's Name (First, Middle, Maiden Surname) unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD N. Calvert Street Suite #300 Baltimore Frieda Jones-P.O.A. Dec: R
Baltimore, N 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cem. 20a. Method of Disposition 20c. Location - City or Town, State Department of F Important: If ite any injury or oth XBurial 2 Cremation 3 Removal from State 05-13-10 Lansdowne, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service License 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Programme disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** robrymenles quantially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Demento or Attending Physician: The law requires that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy death? performed' 1 ☐ Yes 2 ☐ NO 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 40 မ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 🗌 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural 1 Yes 2 No 2 Accident
3 Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier within 2 To the I 29b. Signature and title of certifier 29c. License number D31464 121 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar A. Ita-Fitmi

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

\$21

MD

ENTAR ST SNITE 368 BALTIMORE MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ May 8, 2010 6:38 PM John J. Toohey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Min (Month Day, 1**X**□ M 2 □ F Michigan Director 49 Yrs 1960 212-88-9387 \$ep. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Glen Burnie Anne Arundel Maryland 10f. Zip Code 10g. Citizen of What Country? Funeral USA 8067 Green Orchard Road 21061 12. Was Decedent Ever in U.S. Armed Forces?,
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black. White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No Specify: 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Culinary Chef Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William D. Toohey Catherine T. Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8843 Beaver Creek Lane Gaithersburg, MD 20879 William Toohey - Brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Gate of Heaven 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/14/2010 Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Ph sician/ XACERBATION - OBSTRUCTUE CUTE disease or condition Medical resulting in death) to (or as a consequence of) Examiner AIRWAY DISEASE YEARS Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Dav Pregnant at time of death 2 No ed by the a detached f g | Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident injury 5 Pending s after death.

I Director: Aft d in by the fur 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital of 24 hours at Euneral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or inventioning in the control of the cause of examination and/or inventioning in the control of the cause of examination and/or inventioning in the cause of examination and/or inventioning in the cause of examination and/or inventioning in the cause of examination and/or inventioning in the cause of examination and or invention and Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year) 1 2 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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RAYMOND

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D003637

BRAVERTON ST

2010

EOGEWATER, MO 21037

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year Month 12.01 A M Taylor MA 2010 Μ. 06 /Medical Joyce 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL AGNES BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, O7 25 Year) 33 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Director 76 MD 218-28-7344 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinator rust be notified at **Funeral Director** 1 Yes 2 No Baltimore MD NA permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other traumating exercises. 10e. Street and Number 10g, Citizen of What Country? U.S.A. 21216 2503 Queenanne 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married If Yes, Give Year or Dates: þ 1 ☐ Yes 2 📉 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 4yrs Teacher School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ William Young Bessie Henry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Taylor-Husband 2503 Queenanne Road, Baltimore, Md 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) On-Site 5/12/2010 Baltimore, Md 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee e 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** NTRAVENTRICULAR HEMORRHAG HOURS resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician and the burial-transit Exami Due to (or as a consequence of): Box 68760 Physician/Medical attending pl IE EEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 0 After this certificate has been signed by the stuneral director, page 2 should be detached it ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□Yes 2☑No Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊿Yes 2□No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending To the Hospina.
within 24 hours after death.
To the Funeral Director: Aftr 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide : Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) RESIDENT PHYSICIAN P24060

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5. CATON AYE, BALTIMORE, MD 21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 7.14AM nes 2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 259 Waxt<u>er Way</u> <u>Baltimore</u> Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 F Months Days Hours Min. Mary Land (Month, Day, Year) 08/04/1940 **Director** 220-36-1357 69 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🖔 Yes 2 🗆 No MD Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 259 Waxter Way 21217 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: Black Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the once. Social Worker Social Assistance Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Robert Wilson Aleese Sophie Ernest Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Uncles / Daughter 3 N. Broadway, Baltimore, MD 21231 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 05/05/2010 Hanover, Maryland 21. Signature of uneral Service Licenses Anatomy Gifts Registry 22. Name and Address of Facility 7522 Connelley Dr., Ste. P, Hanover, MD 21076 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, shock, or heart failure. List one cause on each line. Onset and Death Immediate Cause (Final Physician/ Breast disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) ending physician and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed ause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?
1 ☐ Yes 2 No Day Year Pregnant at time of death 1 Yes 2 g 9 Unknown Yes detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be c 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 AN has page 2 this certificate 1 Yes 2 No Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Yes 2 XNo ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify Manner of Death s after death.

I Director: After to the second in by the funeral 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: (Month, Day, Year) 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 A Homicide determined within 24 hours a To the Funeral D To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month Day, Year) D 68975 son who completed cause of death (Item 23a) (Type, Print) HUSAN 1650 Orlean Street, Baltimore, MD 21287 TIW State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Anthony Ventura 2010 2:23 A. M 11 May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore County Stella Maris Hospice Timonium If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Nov. 25 **Funeral** 9. Birthplace (State or Foreign 1 M 2 □ F Months Hours Min. Calascibetta.Sicily Director 1218-01-8426 91 1918 Nov. Usual Residence of Decedent show ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Maryland 1 🗌 Yes 2 🔀 No Baltimore County Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must b Funeral 2300 Dulaney Valley Road 21093 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give 1035 3 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: "natural", 3 Widowed 4 Divorced Year or Dates.1935-38 other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) pernit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me College (1-4 or 5+)
N/A Elementary/Seconday (0-12) 07 Truck Driver Halls Motor Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gaetana Bruno Agatino Ventura 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) West Palm Beach, FL. 33412 Mrs. Dorothy M. Ungerer(Daughter 10953 Egret Pointe Lane Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State (Baltimore Co.) Timonium, Maryland 1 X Burial 2 Cremation 3 Removal from State May 14,2010 Dulaney Valley Mem. Gard. 4 Donation 5 Other (Specify) Signati 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Center, P.A. Funeral Se Jeffrey L. Gair, Sr. 2325 York Road Timonium, Maryland e disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CONGESTIVE HEART FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death has been signed by the e 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 No Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform Yes 2 death? Director: After this certificate 2 X No 1 🗌 Yes 2 🗀 No Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \blacksquare Other (Specify) **HOSPICE** 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural work? 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide 24 hours after Funeral Direc determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. only one 3 🕱 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature an 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

31. Date filed (Month, Day, Year)

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DHMH 17 Rev 7/2009

State Registrar

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Assistant Medical Examiner

32 Registrar's Signatus

30. Name and address of person who completed cause of death (Item 23a)

OCME

Victor Weedn MD JD

31. Date filed (Month, Day, Year

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2010 Physician/ SANDRA 3:14 AM WILLIAMS A 1)5 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE UNIVERSITY OF MARYLAND MEDICAL CENTA If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 Months Hours 0170371966 Maryland 218-78-5529 44 **Director** Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1X Yes 2 ☐ No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ö "natural", or items 23a o Funeral 817 Brooks Lane 21217 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Black 3 🗌 Widowed 4 🗎 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natury ny or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 1 2th Grade College (1-4 or 5+) Care Provider Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Walter Williams Orelia Aqurs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 817 Brooks Lane, Baltimore, MD 21217 Joseph Morton(brother) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Woodlawn Cem. 05/15/10 Baltimore, MD 21. Signature of Funeral Service Licensee Joseph Addrs of Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastano breast cancer disease or condition resulting in death) Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter organizing Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 1 ☐ tes ∠ ☐ 9 ☐ Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy director, page 2 performed certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 5 Pending 2 🗌 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🖆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) P24416 106 12010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHM11 17 Flow 7/2009

State

22 S. GREENE

32. Registrar's Signatur

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31. Date filed (Month, Day, Year)

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ST. BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death c. County of Death Examiner Baltimore Randallstown Northwest Hospital 7. Age (In yrs. last birthday) f Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1√ M 2□ F Months Days Hours Min. 220-74-6098 62 Director 9-30-1947 Washington DC Usual Residence of Decedent death with the Maryland 10b. County 10c City Town or Location 10a State 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at Director ty∑Yes 2 No Maryland Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21133 3606 Chapman Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after on and Mental Hygiene. 1 Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 No Specify δ White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 None None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Juanita F. Moore Edwin P. Wenttang ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 13535 Youngwood Turn Bowie, Maryland 20715 - Brothet Pau1 Wenttang other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Date Pages 1 permit. Page: Department of Important: If any Injury or once. = 5 1 ☐ Burial 2 🔀 Cremation 3 Removal from State 5/9/2010 Atlantic Crematory Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Rd. Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Ye ar Day 5 Other (specify) 1 □Yes 2 □ No. 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 ☐ Yes 2 ☐ No 3 Probably ™ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? has autopsy certificate l 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 1 ☐ Yes S apital: 1 ☐ Inpatient 28a. Date of Injury (Month Day) 2 ER/Outpatient 3 DOA Certification: To After this her (Specify) funeral 27. Mapner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 ☐Pending investigation 1 ☐ Yes 2 ☐ No after death filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier License number Date signed (Month, Day, Year)

State Registrar 30. Name and

31. Date filed (Month, Day, Year)

ress of person

DHMH 17 Rev 1/2001

use of death (Ite

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#5perFH, G903, 5/13/2010, WS
State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month _ Woodfolk Roderick Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 € M 2 □ F Months Days Hours Min (Month h, Day, Year) Director 218-42-4284 63 46 MD Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a o Funeral 3700 Greenspring Ave U.S.A 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black White etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2x No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Year or Dates Black permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once." 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade <u>Unemployed</u> na Unemployed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clarence Woodfolk Lorraine Wynn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Stephanie Miller-Sister</u> 3927 Annellen Road, Baltimore, Md 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 5/8/2010 Woodlawn, Md 21. Signature of Funeral Service License 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) arrhythmia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) Yes page 2 should be detached signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabete 1 Yes 2 No 3 Probably 4 Tonknown Peripheral Vascular disease 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has performed? 2 No 1 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မ 1 Inpatient 2 FR/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending Accident Investigation 24 hours after deatl Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by determined Medical 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I only one) 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) 6,2010 may D006268 unn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lathleen 31. Date filed (Month, Day, Year) 32. Registrar's State 1 2 2010 auto Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AMONTO Physician/ Harry Gordon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County General Hagerstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Aug. 20 1 ፟ M 2 □ Hours 1947 Maryland Director 219-44-4050 62 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 ☐ No <u>Maryland</u> Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a Funeral 123 Clarkson Avenue 21740 United States items death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 9 1 Never Married 2 Married Completed by ☐ Yes Yes, Give 72 hours after Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 X No Specify. Specify: "natural", 3 ☑ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 7 th and Mental Hygiene. ?7 is marked other than marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Construction Mason Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clyde R. Ambush Dorothy E. Wolfe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Stephanie E. Moses / Daughter Gettysburg, Pennsylvania 17325 Biglerville Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 permit. Page 1 Department of Important: If it any injury or o April 30 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Gettysburg, Pennsylvania Evergreen Cemetery 2010 22. Name and Address of Facility 21. Sig. ture of uperal Service Licensee Stauffer Funeral Homes, P.A. Frederick, Maryland 21702 Opossumtown Pike 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): that the death certificate be executed emmens and that initiated events Due to (or as a consequence of): resulting in death) Last ı physician a s the burial⁴ Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death the 9 Unknown 9 Unknown P.O. I þ signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? p Records, 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed een 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certifica e has t Hospital or Attending Physician: Telaw autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No director, p Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 🔀 No 2 1 🕱 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After t Certificate: 1 X Natural 5 Pending work?
1 Yes 2 🗌 No death. n 24 hours after death e Funeral Director: A eleted filled in by the fo 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifier

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State Registrar 32. Registrar's Signature

antietanSt. Hagerstown MD 21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ .5.CPM BIJUL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GAITHERSBURG MONTGOMERY 8. Date of Birth (Month, Day, 02 04 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 58 Hours Director Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Funeral Director GAITHERSBURG 1 X Yes 2 □ No MD MONTGOMERY 10e. Street and Number 10g. Citizen of What Country? 20878 LEATHERLEAF 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) NGINEER Be 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) ABDULKADER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 6 7-7 LEATHERLEAF CT. GAITHERSBURG /15E 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 □ Cremation 3 □ Removal from State 28/10 FREDERICK MD. ☐ Donation 5 ☐ Other (Specify) FUNERALSER 22. Name and Address of Facility ADEN MUSL/M 21. Signature of Funeral Service Licensee EAS . WOODBRIDGE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final SMALL Physician/ NON disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine lary, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of: To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death 1 ☐ Yes 2 № g ☐ Unknown a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Were autopsy findings available prior to completion of cause of death? 24a. Was an Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 M No Hospital: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pendina 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number D32407 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9707 MEDICAL CTR. DR. ROCKVILLE MD. 20850 JOSEPH M. HAGGERTY MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 8 2010 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 7:53 a[™] 2010 HAROLD EDWARD ANDREW, JR. MAY 6, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 125 Island Creek Rd. Centreville Queen Anne's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | April 9. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 XM 2 □ F Maryland 61 Director 217-54-7254 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertial Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other than the marker or officed a ury or other traumatic event, Ite Positical Expension. 10c. City, Town or Location 10d. Inside City Limits 10a, State 1 ☐ Yes 2 XNo Directo MD Oueen Anne's Centreville 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 125 Island Creek Rd. 21617 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian. 11. Marital Status 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify: White \$ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Solid Waste Supervisor Public Works 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harold Edward Andrew, Sr. Lydia Magrogan မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other trai once. Gladys Russum (sister) 33069 Walnut Tree Rd. Millington, MD. 21651 Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Memorial Park 5/11/10 4 ☐ Donation 5 ☐ Other (Specify) 21. Signaluar Francial Straice Live 22. Name and Address of Facility Galena Funeral Home of Stephen L. Schaech M00510 118 West Cross St. Galena, MD. 21635 Approximate Interval Between Onset and Death Rart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause or each line. Immediate Cause Final NDITEN **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner RE KUI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed VIEN attending physician and for use as the burial-trar Due to (or /s a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal deat
4 Pregnant at time of death 3 Ectopic pregnancy 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s performed 1 □Yes 2 🗆 🗖 C 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 📑 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation nours after death.

neral Director: A
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To the Funeral I
completely filled Hospital Medical 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) Signature and title of certifier 29b mmp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patrick Shanahan, M.D. 120 Speer Rd. Chestertown, MD. 21620 31. Date filed (Month, Day, Year) State Registrar

) > DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month ebecca Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis . Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8 Date of Birth Funeral (Month, Day, Year) 1 🗆 M 2 🗶 F Months Director 245-64-1225 1945 Usual Residence of Decedent 28a-f shov 10a. State 10b County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at **Funeral Director** Anne Arundel Arnold 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 21012 705 Mashie Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🄀 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 X Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Administrative and Mental Hygier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental Hitem 27 is marked of other traumatic even ဂ္ John Wilson Myrtle Edge 19a. Informant's Name/Relationship (Type, Print) Edward Almes/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of April Date permit. Page 1 a
Department of H
Important: If ite
any injury or otl
once. cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 23, 4 Donation 5 Other (Specify) Metro Crematory 2010 22. Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examil To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death been signed by the should be detached □ Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 24a. Was an page 2 performe funeral director, Be 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) Hospital Other: ပ္ 1 ☐ Yes 2 🗷 No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No М Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29c. License number 10 ause of death (Item 23a) (Type, Print)

Federal Government 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
705 Mashie Court Arnold, MD 21012 20c. Location - City or Town, State Baltimore, MD Severna Park Funeral H Severna Park, MD 21146 Onset and Death 23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

3. Time of Death

10d. Inside City Limits

1 Yes 2 X No

555 PM

Yea

USA

White

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 20<u>10</u> Month **Physician** 24, 3:30 p M Robert Neale Allman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll 1000 Weller Circle Apt. 308 Westminster If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. TACM 2□ F West Virginia Director 217-24-6000 81 Apr 29, 1928 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is medical Evander in ust be notified at 1 XYes 2 No Director Westminster MD Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21158 Funeral 1000 Weller Circle Apt. 308 12. Was Decedent Ever in U.S.
Armed Forces?
1 □ Yes 2 □ No 1946
If Yes, Give
Year or Dates: 1948 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ģ 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County filed withir Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Instrumental Music Teacher Schools 2 should be filed w and Mental Hygie is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Dalton Allman Bonnie Nangle ပ permit. Pages 1 and 2 should Department of Health and Mer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i Apt. 308 Westminster, MD 21158 1000 Weller Cir. Norma Allman 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hampstead, Maryland Carroll Cremation Inc 4/26/10 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA ignatu e of Funeral Service Licen 412 Washington RD. Westminster, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between enset and Death 10 Immediate Cause (Final **Physician** NON disease or condition resulting in death) /Medical Due to (or as a con-Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of, be executed and burial-trar Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical The law requires that the death certificate IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 0 signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform this certificate 1 ☐ Yes 2 ☐ No 2 1 ☐ Yes To the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □No 1 Inpatient 2 ER/Outpatient 3 DOA 2 funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 Accident 28b. Time of . Injury at Work? 28d. Describe how injury occurred After Certification Division 5 ☐ Pending investigation death. 1 Director: A d in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and magner stated 29b. Signature and title of certifig 29d. Date signed (Month, Day, Year) Not like 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 75116 OH, THEWINTED Exter Street

Registrar
DHMH 17 Rev 1/2001

State

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MATY 4,2010 THELMA GWYNETTE BENDER 11:46A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** P.G.GENERAL HOSPITAL PRINCE GEORGES CHEVERLY 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Funeral 1 M 2 TXF Months Days Hours Min. (Month, Day, Year, 12-22-1 Country) 216-18-5138 90 Director 1919 MD Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director MD. CHARLES WALDORF 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3735 LEONARDTOWN ROAD Funeral 20601 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 Xio
If Yes, Give Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) MARYLAND BANK and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) BANK TELLER TRUST 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JOSEPH CLEVELAND MONTGOMERY MARY GWYNETTE WILLETT and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health a item 27 i DIANE HOFFMAN-DAUGHTER 13265 RYCEVILLE RD. CHARLOTTE HALL, MD. 20622 Baltimore, 20a. Method of Disposition Method of Disposition

1

| Burial | 2 □ Cremation | 3 □ Removal from State | cemetery,
| TRINITY | TRINITY 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite injury or MEM.GARDENS: 5-8-2010 WALDORF, MD. 4 ☐ Donation 5 ☐ Other (Specify) M00479 2. Name and Address of Facility RAYMOND FUNERAL LA PLATA, ARYLAND 21. Signature of Fuperal Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 11thacereby SSIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Unknown Month Day Year No ed by the a 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Yes 2 No After this certificate I 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No 1 Inpatient 2 Certificate: To ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28d. Describe how injury occurred battle oom at 28c. Injury at 5 Pending To the most after death.

To the Funeral Director: Aft Natural at home 1 🗌 Yes 2-Accident 5/4/2010 2:00 A M Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Home Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of de Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registra State Registrar

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

ORIGINAL

Dir

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9:00 AM Mary Bovbjerg 2010 APRIL 25 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner La Plata MEDICAL CENTER CHARLES CIVISTA | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | September 6,1925 5. Social Security Number Birthplace (State or Foreign Country) 6 Sev 7. Age (In yrs. last birthday) **Funeral** Min. (Month, Da September 1 □ M 2√□ F 579-34-5453 84 Director Maryland Usual Residence of Decedent death with the Maryland 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location items 23a or 28a-f show event, the Madical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Charles Bel Alton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9795 Bel Alton Newtown Road 20611 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 ō 1 ☐ Yes 2 X No Specify: White Completed by Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Drug Store other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental Clarence W. Tayman Myrtle Tayman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Kathy Jones/Daughter P.O. Box 143, Bel Alton, MD 20611 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Florida National Cem. 5/3/2010 4 ☐ Donation 5 ☐ Other (Specify) Bushnell, FL M00945AREHART-ECHULS FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee auro 211 St. Mary's Ave. La Plata, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) COTEL /Medical Due to (or as a consequence of): Examiner avlure Sequentially list conditions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy Day 5 Other (specify) the 1 □Yes 2 □No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 No 3 Probably 4 \textsup \t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 1 NO After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 THO 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ieral Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ladevi Nirma Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

MAR

ERG.

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3008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

The law requires that the death certificate be executed Box 68760 P.O. Division of Vital Records, has or Attending Physician:

filled in by the funeral director, Hospital 24 hours completed To the within 2

3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)		n (Street and Number or Rural Route Number, Town, State)
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred to the basis of examination and/or investigation only one) 2 Medical Examiner: On the basis of examination and/or investigation only one)	n, in my opinion, death occurred at the time, da	te and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifie)	29c. License number	29d. Date signed (Month, Day, Year)

		Δ
	30. Name	and a
- 1	A - '	- 1

To Be

Certificate:

Medical

PR

5 Pending

Investigation

D67657

28c. Injury at

work? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

4/23/10

autopsy perform

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Yes 2 No

28d. Describe how injury occurred

ddress of person who completed cause of death (Item 23a) (Type, Print)

Anish Desai 31. Date filed (Month, Day, Year)

acidosis

1 ☐ Yes 2 🗶 No

Accident

examiner?

27. Manner of Death

1 Natural

25. Was case referred to medical

400 W 7th St. 32. Registrar's Signature

28a. Date of injury (Month, Day, Year)

Frederick, MD 21701

State

Registrar

Inpatient 2 🗆 ER/Outpatient 3 🗀 DOA

28b. Time of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 2040 fm Mary Kathryn Burt 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington Hagerstown Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Meyersdale, pa 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Month, Day, Year) 6 - 25 - 1940 Days 1 □ M 2XDX Director 207-30-4372 69 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits Director 1 X Yes 2 □ No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 856 Jefferson Boulevard 21740 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14, Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Completed 3 TWidowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Cafeteria Worker School District any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F rs marked o ဂ Eleanor (Lewis) Hutzell William C. Hutzell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Renee Bradford/Daughter 19626 Cool Hollow Way Hagerstown. MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 04-23-10 Meversdale. Union Cemetery CC0376 21. Signature of Funeral Service Licens 22. Name and Address of Facility 325 Main Street/PO Box 119 Villia Meversdale PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ MASSIVE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed HYPERCIPIOEMIA that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial-Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 □ Fetal useal □ Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☑ No Month 5 Other (specify) Day P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? tor: After this certificate has been signed the funeral director, page 2 should be der ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 🔼 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident within 24 hours after death

To the Funeral Director, completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (60 M) MINITOUN 1190 MYNET GIMYLMUS 31. Date filed (Month, Day, Year) State APR 26

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State
Registrar Amend#1.PerPhys.PCC5-3-10cr Certificate of Death 1. Decedent's Name (First, Middle, Last) KAMEN 2. Date of Death 2<u>010</u> Physician/ $\operatorname{APRIL}^{\mathsf{Month}}$ 22 9:43 P M KAREN IREECE BELL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S HOSPITAL PRINCE GEORGE'S CHEVERLY If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) Funeral 6. Sex 1 □ M 2 🗓 Months Davs Hours 1953 WASHINGTON, DC Director 577-72-8889 57 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director MD PRINCE GEORGE'S CHEVERLY 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20785 6120 PERRY STREET USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) REGISTERED NURSE GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ FRANK **GENEVA** MAE CORSEY BELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6120 PERRY STREET CHEVERLY, MARYLAND ANDREA MILLER/DGT 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE CREMATORY 4/28/10 RIVERDALE, MARYLAND J. B. JENKINS FUNERAL HOME 21 Signature of Funeral Service Licensee 22. Name and Address of Facility 20785 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Medical resulting in death) Due to (or as a consequence of) Examiner OCARDIA Sequentially list roudifications if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner OBSTRUCTIVE To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events CHRONIC Due to (or as a consequence of resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🛚 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 2 -No 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatuję 29d. Date signed (Month, Day, Year) 006 3688 DID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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DR.

HUSPITAL

CHEVERLY MIS

3001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Elizabeth Black Day 2010 Year Physician/ April 21, 10:30 pM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery Bedford Court Nursing Home Social Security Number 6. Sex 7. Age (In yrs, last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F Hours Dec. 28 Year 1921 460-14-9155 88 Director Texas Usual Residence of Decedent fshow 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at Director Silver Spring Maryland 1 🗆 Yes 2 ੌNo Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA 20906 Funeral 3601 Edelmar Terrace ural", or items 2 Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: Specify: White WWII "natural" 3 Widowed 4 Divorced Year or Dates of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Disabled Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Irma Modina Wheeler James Earl Smith permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 20906 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3701 International Drive, #351, Silver Spring, MD David Paul Black/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 3 20c. Location - City or Town, State cemetery, crematory or other place)
Arlington National
Cemetery 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Arlington, Virginia 2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. After the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Reticulo Sarcoma disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, if any action of the cause. Enter Underlying Cause (Disease or linjury Examine Due to lor as a consequence of the attending physician and thed for use as the burial-transit Atrial Fibrillation Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Pulmonary Embolus Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 5 Other (specify) signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Anemia 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has I autopsy performed? Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 2 X No. မ 1 Yes 4 Xursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident Accident Investigation after death completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

within 24 hours a 2 +1

> State Registrar

(Check

only one) 29b. Signature and title

3 🗌

APR 27

31. Date filed (Month, Day, Year)

of certifier

2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Wilkinson Ninala, MD 344 University Blvd. West, #113, Silver Spring, MD 20901 Registrar's Signature arked

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D45285

29d. Date signed (Month, Day, Year)

April 26, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Morton BRODY Physician/ Apyrii 26, Da 2010 Year 7:05 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Montgomery Examiner Silver Spring 3100 N. Leisure World Blvd, #307 Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 1 M 2 □ F Jan. 18 Year 1925 579-22-7168 Washington, 85 **Director** Usual Residence of Decedent It of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medir al Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Silver Spring Maryland Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 United States 3100 N. Leisure World Blvd., #307 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by 1 Yes 2 No Specify: white Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Grocery, College (1-4 or 5+) Elementary/Seconday (0-12) Distribution Business 0wner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Brodofsky Beatrice Goldman 19a. Informant's Name/Relationship (Type, Print) 3100 N. Leisure World Blvd., #307, Site Zogo and Number of Burd Boute, Number, Glv. 7 Towns Site Zogo and Ing. MD Carol Loesberg Brody, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 s
Department of IImportant: If ite
any injury or ot cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ebanon Cemetery 04/29/2010 Adelphi, MD Μt 21. Signature of Cuneral Service Licensee Torremsky Hebrew Funeral Home MDI 008 20012 254 Carroll St., NW, Washington, DC 23a, Park L Faller the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ caruna Medical resulting in death) ue to (or as a con equence of): Examiner Sequentially list conditions, if any Lacing to immediate cause. Enter Underlying Examin Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician and for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No ☐ Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ည 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After th completed filled in by the funeral 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) 10/26/11 D4722 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) myco Born WEDATO 3289 MD HEUSTO 32. Registrar's Signature State

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O. I

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death April 25 Day 2010 Year Physician/ 11:55 pM Alice Burse Margaret Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Holy Cross Hospital ilver Spring 9. Birthplace (State or Foreign Country) Alabama If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗗 F Months Hours Dec. 23, ar) 191 012-12-1316 94 Director Usual Residence of Decedent 10d, Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location 10a. State iral", or items 23a or 28a-f sho Examiner must be notified at 72 hours after death with the Maryland Director 1 🗆 Yes 2 No P.G. Maryland Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20783 USA 1618 Dayton Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Specify: "natural", Completed 3 X Widowed 4 Divorced Black Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done (life. DO NOT use retired) during most of working al Hygiene. within 7 Elementary/Seconday (0-12) College (1-4 or 5+) 12 Clerical State Government Be traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) d 2 should be file alth and Mental H 27 is marked ot 2 Lee Britt Hattie Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 1618 Dayton Road, Hyattsville, MD 20783 Barbara A. Monroe/Daughter 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 2010 1 Burial 2 Cremation 3 Removal from State 29 VA National Cemetery 4 Donation 5 Other (Specify) Bourne, MA 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spri MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death weeks Immediate Cause (Final disease or condition Physician, Bilateral Frontoparietal CVA Medical resulting in death) Due to (or as a consequence of) Examiner Uncontrolled Hypertension vears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Seizure, secondary to new CVA burial-transit weeks Cause (Disease or iinjury that initiated events and resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be exec attending physician Physician/Medical Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ρ Month Day Year 4 Pregnant a Pregnant at time of death 5 Other (specify) be detached the g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Left Breast Cancer, Osteoarthritis 1 ☐ Yes 2 🕏 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 💆 No this certificate **Division of Vital** Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 \(\sum \) Nursing Home \(5 \sum \) Residence \(6 \sum \) Other (Specify) Hospital: 1 🗌 Yes 2 No မ 1 -Inpatient 2 - ER/Outpatient 3 - DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: After 1 ANatural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: Ai completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated з 🗆 only one) 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifier D0065485 2010 Jupanich 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara Supanich, MD 1500 Forest Glen Road, Silver Spring, MD 20910

Registrar

State

Month Day, Year)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3 AM Jerome Berger Amrt 21 Pay 2010 Year Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Fulton **Examiner** 4c. County of Death Howard Autumn Hill Assisted Living Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country)
 PA **Funeral** 1 🛣 M 2 🗆 F 69 Months Days Min. Ap##1/h, D2/7Year)1940 160-32-6980 Director Usual Residence of Decedent 28a-f shov ed other than "natural", or items 23a or 28a-f shorevent, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No MD Montgomery Olney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18304 Darnell Drive 20832 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in 0.5.
Armed Forces?
1 ₹ Yes 2 □ No
If Yes, Give
Year or Dates. 1960 1 Never Married 2 Married Black, White, etc. þ 1 ☐ Yes 2X No Specify: White Completed Specify: 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) System Analyst US Government marked other Be 17. Father's Name (First, Middle, Last) unould be filk th and Mental Ha 18. Mother's Name (First, Middle, Maiden Surname) ည Benjamin Berger Susan Seidenberg traumatic age 1 and 2 should be ant of Health and Mer it: If item 27 is marky or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Berger - wife 18304 Darnell Drive Olney MD 20832 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place, Judean Memorial Gardens 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/23/2010 Olney, MD 21. Signature of Funeral Service Licer 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels Inc
1170 Rockville Pike Rockville MD 20852 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Interval Betweer Onset and Death Immediate Cause (Final Physician/ disease or condition MINUTE. Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examir and resulting in death) Last Due to (or as a consequence of): physiciar Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months 4 ☐ Pregnant at time of death 9 ☐ Unknown Day the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Completed 1 Yes 2 4 To 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 1 No Yes 2 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes 2 No Other: ည 4 Nursing Home 5 Residence 6 X Other (Specify) Assisted 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work thours after death.
uneral Director: Afted filled in by the fur 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. npleted 1 (Check within 2

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complet 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of cert

31. Date filed (Month, Day, Year)

lot

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

D20094

1411 Madison Park Drive Suite #2B Glen Burnie MD 21061

29d, Date signed (Month, Day, Year)

April 22, 2010

10.	-03068	1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Vayne Maurice	Ва	nks S 1- For State Registrar	tate of Maryla		artment of		nd Menta	l Hygiene	Pos No	201	0 1481
Physici Medical Exam		1. Decedent's Name (First, Midd		Banks				2. Date of D Month	Day	Year	3. Time of Death 2332 hrs
		4a. Facility Name (if not instituti Southern Maryland H	on, give street and nu			4b. City, Town, o	or Location of [April 19 Death	4c	County of De	eath
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye	ear If Under 2	24Hrs. 8. Date of			Birthplace (State or
Director		578-92-5030	1XM 2_F	4	6 Yrs	Months Da		Min.	22,	Fo	oreign Country) DC
*		Usual Residence of Decedent		La au				1106		2703	
i iow any		10a, State 10b, County			, Town or Locati	on	-				10d. Inside City Limits 1 X Yes 2 No
Aaryland 28a-f show 1 at once.	Director	Maryland Princ 10e. Street and Number	e George s	5		10f. Zip Code	Fores	tville	10g. Citiz	zen of What C	
th the Maryla 23a or 28a-f		6507 Insey S	Street				20747				d States
th with ems 23 t be no	Funeral	11. Marital Status 1 Never Married 2 X M		edent Ever in U	J.S. 13. Wa:	s Decedent of H	ispanic Origin	? (Specify Yes or uerto Rican, etc.)	No-		merican Indian, Black,
ter dear			1 Yes	2 No	1		o specify:	dorto rubari, cto.)			Black
5 72 hours after death with the Maryland 11 "natural", or items 23a or 28a-f sho 12 Examiner must be notified at once	d by	15. Decedent's Education (Spe	or Dates:			's Usual Occupa	ation (Give kin			Specify: 1 (ind of Busine	
n 72 h	olete	Elementary/Secondary (0-12)	College (1	-4 or 5+)	during mo	ost of working lif	e. DO NOT us	e retired)			
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	Completed	17. Father's Name (First, Middle	, Last)			Car Sal		lame (First, Middle	Maiden :	Priva	ate
215 be file ntal Hy rked o	Be	, , ,	n Mason Ba	anks			10.11101.101.01	Jean Te			3
O \(\frac{1}{2} \) \(\frac{1} \) \(\frac{1} \) \(\frac{1}{2} \) \(\frac{1}{2} \	ဥ	19a. Informant's Name/Relations	,		9.3			r or Rural Route N	umber, Cit	ty or Town, St	tate, Zip Code)
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati.		Rosalind Ban 20a. Method of Disposition	ks/ Wite	20b.	Place of Disposi			Forestv			20747
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 X Burial 2 Cremation	_	om State	crematory or oth	erplace) crection		April 26 2010	,	· ·	<i>'</i>
altir mit. F partme		Donation 5 Other S Signature of Funeral Service	Licensee C		22. N	ame and Addres		tewart F	uners	1 Home	n, Maryland
		John J. K	Kutha	M	4(JOl Benr	iing Rd	. NE Wa	shine	ton. I	OC 20019
Physician /M i		23a. Part I. Enter the disease, or failure. List only one cause	on each line.			e mode of dying	ı, such as cardi	ac or respiratory a	arrest, shoo	ck, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a								Death
	-	Sequentially list conditions, if any, leading to immediate	b Due to (or as a	consequence	vD·						
	miner	cause. Enter Underlying Cause (Disease or injury that initiated	e						_		
ecuted and transit	Exa	events resulting in death) Last	Due to (or as a d.	consequence o	if):						
D, be exe sician a	edical	UNPENDED	AMENDED								
Box 68760, death certificate be except the attending physician defor use as the burial.	cian/M	IF FEMALE; 23b. Was decedent pregnant in the past 12 months?	23c. If yes, o	utcome of preg rth		aldeath 3	Ectopic pre	egnancy		. Date of deliv Month	very Day Year
OX 6 sath cer attendi				int at time of de	ath -	er (Specify)					1
D. B. tthe de by the ached f	F,	Part II. Other significant conditi			esulting in the un	derlying cause	given in Part I.	23e. Did	tobacco u	se contribute	to the cause of death?
ires that to signed by the detact	d by							_ 1 _ Y	es 2	No 3 P	robably 4 🗸 Unknown
cords law requi	Completed							24a. Wa auto	s an opsy		autopsy findings available to completion of cause of
tal Rec	E S								formed? 2 No	death'	
ital sician: s certif irector,	8	25. Was case referred to medical examiner?	Olamaital, ma	nationt 2	ER/Outpatient		Other] s		
of V ing Phy After thi	٢	1 Yes 2 No 27. Manner of Death	28a. Date o	f Injury	28b. Time of Inj		ry at Work?	28d. Describe	Residen		ner:
ion trendir death. tor: A	atio	1 Natural 5 Pend 2 Accident Inves		Day,Year)		1	Yes 2 No				
Division of Vital Records, Hospital or Attending Physician: The law require 24 hours after death. Funeral Director: After this certificate has been si tely filled in by the funeral director, page 2 should b	Certification:	3 Suicide 6 Could		of Injury - At ho	ome, farm, street	factory, office b	ouilding, etc.	28f. Location or Town,		d Number or I	Rural Route Number, City
Hospi 24 hou Funer tely fil		29a. Certifier (Check only 1 Certifying Ph	nysician: To the best								
To the within 2 To the complet	Medical	one) 2 Medical Exar 29b. Signature and title of certifie	miner: On the basis of and manner sta		nd/or investigatio	n, in my opinion		ed at the time, date			
		110 4	1	Ta		O.C.I		OCME		ate signed (N 20, 2010	Month, Day, Year)
0 -	}	30. Name and address of person		of death (Item	23a)						
13		Theodore M. King, Jr.,		nt Medical E		11 Penn Str	reet, Baltim	ore, MD 2120)1		
Sta Registi	~~	31. Date filed (Month, Day, Year) APR 2 9 2010	Senera 32. Reg	istrar's Signati	arted						

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>010</u> Physician/ Month Dora L. Bartley 1830 April 10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Prince George's Hospital Center Cheverly 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🖾 F Months Days Hours South Carolina Director 095-26-6590 Yrs 78 1931 Usual Residence of Decedent 28a-f shov 10a. State 10b. County ral", or items 23a or 28a-f shor Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Waldorf Maryland Prince George's 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20601 703 Eucla Drive United States hours after death 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: If Yes, Give Year or Dates Black. "natural", Specify: 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Private Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Norman Murphy Louvenia Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra 703 Eucla Drive Waldorf, Maryland 20601 Josh Bartley/ Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State April 23, 4 Donation 5 Other (Specify) Lee's Crematory Clinton, Maryland 2010 22. Name and Address of Facility Stewart Funeral Home, Inc. of Funeral Serv 20019 4001 Benning Rd. NE Washington, DC 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ a Respiratory Failure/ Aspiration Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** b. Anoxia, Encephalopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events End Stage Renal Disease/ History of CVA and tran Due to (or as a consequence of): resulting in death) Last burialphysician the burial Physician/Medical Atrial Fibrillation, S/P Pacemaker Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 4 Pregnant at time of death 9 Unknown signed by the a 9 Unknown Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy performed? Yes 2 K No death? 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🕱 No ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🗵 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State)

State Registrar

Medical

29a. Certifler

(Check

29b. Signature and title of certific

Nadar A. Dakak

31. Date filed (Month, Day, Year APR 2 9 2010

0-2

3001 Hospital Drive 32. Registrar' Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month. Dav. Year)

April 12, 2010

20785

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D46065

Cheverly, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Day 2220 M Margueritte Coena Kelly Bracy 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year 1 □ M 2 🕏 F Days Hours Director 200-18-0684 86 4 1924Phila. Apr. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant of Health and arked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov 1 MYes 2 □ No Directo Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2015 East West Hyghway 20910-2602 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 € No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No <u>Ş</u> Specify: Black 3 ₺ Widowed 4 □ Divorced Completed er than "natur, 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Sales Manager Years 27 is marked other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Edmund Kelly Hattie Kea 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margueritte Bracy Brown 4713 Queens Chapel Ter., NE Wash.DC20017 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 11 Cemetery 4/23/10 22. Name and Address of Facility Fletcher Philadelphia,PA Hill 21. Signature of Funeral Service Licensee cc0278 6610-12 Germantown, Ave. Phila. PA 19119 23a. Part 1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Hyper Natremia disease or condition resulting in death) Days / /Medical Due to (or as a consequence of): Examiner Volume Depletion Days Sequentially list conditions, any cause in the July cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Drie to for as a consequence of law requires that the death certificate be executed physician and s the burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Demenia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown s peen s Decubitus Ulcer 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy performed? Yes 2 No Vital certificate 1 ☐ Yes 2 No 1 ☐ Yes Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ot this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death After 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation nours after death.

neral Director: Affilled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital or hours Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the Hos within 24 h To the Fur (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

Aupta, MD

Suresh K.

9801 Georgia Ave. Suite 220 Silver Spring, MD 20902

of person who completed cause of death (Item 23a) (Type, Print)

D-32332

4/17/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 18 2018 Willie Bradford 7:30AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Paint Branch Assisted Living Adelphi Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1**X** M 2 □ F Days Hours Months Director 250-05-4529 3/7/1918 Country) Yrs SC Usual Residence of Decedent show 10a. State 10b. County with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 X Yes 2 No MD Seat Pleasant <u>Prince Georges</u> 10e. Street and Number ō 10g. Citizen of What Country? Funeral items 23a 7220 Hylton Street 20743 USA 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. ö 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 X Yes 2 3 → Widowed 4 □ Divorced If Yes, Give ukn Year or Dates. 1 Yes 2X No Specify: "natural", Completed Specify: Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e 1 and 2 should be filed within 72 of Health and Mental Hygiene. If item 27 is marked other than " Ir other traumatic event, the Mer than U.S. Printing Office Elementary/Seconday (0-12) College (1-4 or 5+) Courier Federal Government ukn Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sam Nicholas Bradford Elizabeth Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) General Bradford/Brother 7911 Wildwood Dr. Takoma Park,MD 20912 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1.2
Department of Important: If it any injury or of once. ō 1 X Burial 2 Cremation 3 Removal from State George Washington4/24/10 4 Donation 5 Other (Specify) Hyattsville,MD of Funeral Service L 22. Name and Address of FacilityLatney's Funeral Home, Inc. cc0278 3831 Georgia Ave. NE Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Dementia Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): e Hospital or Attending Physician: The law requires that the death certificate be executed 124 hours after death.

From Princial Director: After this certificate has been signed by the attending. Cause (Disease or iinjury that initiated events resulting in death) Last use as the burial-transi been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Diabetes Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ♣ Unknown Coronary Artery Disease Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsv perform death? 1 Yes 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 1 Tyes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ♣ Other (Spec 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural injury 5 Pending 1 🗌 Yes 2 🗌 No Accident
Suicide completed filled in by the Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the Pwithin 2 only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 53235 4/21/2010

State

Registrar

Ave.

Laurel MD

20707

Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3635

32. Registrar's Signature

MD

Ηi

2

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day SARAH CECILIA BANDY 2010 Mav 4 12:37AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 212-82-7211 Director 6/1963 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Director PA York 1 ☐ Yes A No Fawn Grove 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 517 Mt. Olivet Church Road 17321 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2X Married 1 Yes 2 If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No Specify. Completed by Specify: White 3 Widowed 4 Divorced the Madical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fili tment of Health and Mental H tant: If item 27 is marked ott Be Theodore Winkler 2 Sarah Cecilia Raspe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 3 2 1 19a. Informant's Name/Relationship (Type. Print) Olivet Church Rd., Fawn Grove, Louis A. Bandy, Jr./Spouse 517 Mt. other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If its any Injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Mem.Gdns. 5/7/2010 Bel Air, MD 21. Signature of Funeral Service License 22. Name and Address of Facility /sunver Harkins Funeral Home, Inc., Delta, PA17314 23a. Part 1. Enter the disease, o complications that cau ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** conongra 4 ears disease or condition resulting in death) /Medical Due to (or as a consequency of): Examiner Scleroderma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year 5 ☐ Other (specify) 200 No ned by the a detached f 1 ☐ Yes 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 1 □Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2. No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 1 □Yes 2 □No 2 Accident 3 Suicide 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

Division of Vital Records, P.O. Box 68760, after death Director: completely filled in by the e Funeral I within 2 To the

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

State Registrar

Medical

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2010 MARY Apri. 2:49 Α Medical BRANDENBURG 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick Social Security Number 213-38-6170 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Days Hours Month, Day, Feb. 6 Mary Land Director 74 Usual Residence of Decedent 3a or 28a-f show t be notified at 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick Maryland Mt. Airy 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4316 Langdon Drive 21771 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: If Yes, Give 3 ₩ Widowed 4 □ Divorced Specify: White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Dwight Talmadge Walker Ruth Clementine Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Nancy Raines daughter 4316 Langdon Drive Mt. Airy, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ō Important: If it any injury or o cemetery, crematory or other place) 1 ☐ Burial 2XXCremation 3 ☐ Removal from State South Carroll Crematory 4/26/10 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, 1212 W. Old Liberty Road Winfield, MD 21. Signatur Funeral Service Licensee Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Imphediate Cause (Final Onset and Death Cardiopulmonary Physician/ Arrest did se or condition resulting in death) Medical Due to (or as a consequence of): Examiner Acute Respira Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami the attending physician and hed for use as the burial-transit Stroke the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Day 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed' 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 \(\to \) Nursing Home 5 \(\to \) Residence 6 \(\to \) Other (Specify) 1 🗌 Yes 2 🔀 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural iniury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation upleted filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Physician 00068977 04-24-10 WIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shoulb Ali 7th St. 400 W Frederick, MD 2170

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Resistrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month April 2 Day 2010 NAOMI ELEANOR BAKER 10:20 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4h City Town or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 220-72-9831 1 🗆 M 2 💢 🕏 Months Davs Hours Min (Month, Day, $\mathrm{MD}^{\scriptscriptstyle (contry)}$ Director /14/1927 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Frederick Myersville 1 Yes 2 No 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3938 Brethren Church Rd. 21773 USA items death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ò Completed by 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 □ Divorced If Yes, Give Year or Dates "natural", SpecifyWhite other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lloyd Stine Nellie Martz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21773 Conard Baker (Son) 3938 Brethren Church Rd. Myersville. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Bural 2 Cremation 3 Removal from State any injury or Lutheran cemetery 4/26/2010 Middletown, MD Fundral Servi ature Donald B. Thompson Funeral Home POB 18, Middletown, MD 21769 ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death heart failure. List only of e cause on each line Immediate Cause (Final Prysician/ Medical Sepsis disease or condition resulting in death) *Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of) that the death certificate be executed burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? for Month Pregnant at time of death the detached 9 Unknown Unknow à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 No ပ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 067657 04/21/2010 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Anish Desai MD 400 W. 7th St., Frederick, MD 21701

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

26

32. Registrar's Signature

BARRAM.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year \underline{A}^M Rude11 Carrol1 April 20, 2010 6:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Health Care at College View
5. Social Security Number | 6. Sex | 7. Age (In yrs. last birth Frederick Frederick 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**∏** M 2□ F Months Days Hours 91 Director June 30, 1918 217-36-6281 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exercites for most be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Maryland Montgomery Clarksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral <u>13224 Lewisdale Road</u> 20871 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2√∑No Specify: Specify: White à 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farming 12 Dairy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leslie G. Beall <u>Bessie</u> Lewis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert C. Beall - Son 26400 Clarksburg Road, Clarksburg, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Bethesda Meth. Cem. 4/26/2010 4 ☐ Donation 5 ☐ Other (Specify) Damascus, Maryland 22. Name and Address of Facility . Signature of Funeral Service Licensee Molesworth-Williams P.A., Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20872
Approximate
Interval Between
Onset and Death Immediate Cause (Final **Physician** avdromyop disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 Be Completed by Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Daÿ Year 5 Other (specify) Division of Vital Records, P.O. 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | ₩o Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural in 24 hours after use... the Funeral Director: After the Funeral Director of the fur 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Frederick MD 2170) Shah 65 c Thomas Hemen 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** May Earl H. Brown 2010 0055 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Elkton Care and Rehabilitation Center E1kton Ceci1 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. **Director** 79 SEPT 27, 1930 216-28-8238 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, If e Medical Examir er must be notified at Director 1 ☐ Yes 2 X No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 114 West Thomson Drive Funeral 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 💢 No Specify: δ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Automobile Elementary/Secondary (0-12) College (1-4or 5+) Painter Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willard Brown ဂ္ Cora Riggs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Department of Health Important: If item 27 any injury or other to once. Betty C. Brown/Wife 114 W. Thomson Drive, Elkton, 20b. Place of Disposition (Name of Chemetery, crematory or other place)
Cherry Hill
Methodist Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State May 10, 4 Donation 5 Dother (Specify) 2010 Cherry Hill, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Hicks Home for Funerals, 103 W. Stockton Street, Elkton, MD 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SE PSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner NEPHONO LITHASIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner the burial-transit VREBRO VASULLA Physician: The law requires that the death certificate be execut Due to (or as a consequence attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Day Year 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident death. 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only

Division of Vital Records, P.O. Box 68760; Hospital or Attending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A

6

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

RAD 126 32. Registrar's Signature

PULA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

v.

DHMH 17 Rev 1/2001

A EAST

29c. License number

DO065733

14614

STREET

29d. Date signed (Month, Day, Year)

15CKTON, MD 21921

04/10

		Please	Type or Print				_		egible.	
		For State Registrar	State of Mary		tificate of I			Reg. No.	010	1481
Physicia		1. Decedent's Name (First, Middle, Las Charles Martin					2. Date of De Month April	2 ^{Day}	201 ^{Year}	3. Time of Death 3:00 A
Medic Examin		4a. Facility Name (if not institution, give	,		4b. City, Town, o	or Location of Deatl		4c. Co	unty of Death	
Funeral Director		212 34 4117	ex 7. Age (In	yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days				9. Birth Coun	place (State or Foreign htry) MD
Maryland 28a-f show otified at	Director	Usual Residence of Decedent 10a. State 10b. County MD Anne An		c. City, Town or Loc	ation igewater				1	10d. Inside City Limits 1 ☐ Yes 2XXN
/ith the 23a or st be n		10e. Street and Number			10f. Zip Code	1037			of What Cour	itry?
1 and 2 should be filed within 72 hours after death with the Manyland of Health and Mental Hygiene. The teath and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ed by Funeral	115 Tarragon Lane 11. Marital Status 1 Never Married XX Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? **XX*Yes 2 \sum No If Yes, Give Year or Dates.	Vietnam If	Vas Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14.	USA Race - Americ Black, White, ecify: Wh	
vithin 72 hour jiene. er than "natu the Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12)		(Give k	ent's Usual Occup ind of work done O NOT use retired) Attorney	during most of wor	rking		of Business In	dustry Practice
d be filed v Mental Hyg arked othe tic event,	To Be	17. Father's Name (First, Middle, Last) John L. Carlson		-			me (First, Middle,	, Maiden Surr		ractice
should h and h 7 is me trauma		19a. Informant's Name/Relationship (T)	/pe, Print)			and Number or Ru				Code)
age 1 and 2 int of Healt t: If item 2 7 or other		Mary H. Carlson 20a. Method of Disposition 1 Burial XX Cremation 3	Removal from State	Ob. Place of Dispos cemetery, crem	sition (Name of eatory or other plac		Date	20c. Locat	ion - City or To	
permit. Page 1 a Department of I Important: If ite any injury or ot		4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Loens		Atlantic 22.		ry 4/22 ess of Facility Ha	2/2010 ardesty		Burnie 1 Home	
20 E 20 20		23a. Part 1. Enter the disease, or com	plications that caused the			ly Ave.			21401	Approximate
h sician/ Medical Examiner		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or s a cor	stive he	eart fo	ailure				Interval Between Onset and Death
	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Jscher	isequence of j.	rd. smys	pathy				6 manth.
ite be executed hysician and he burial-transit	lical Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):	mellit	etron US				Byears
to the noppital or Attending Pnysician; the law fequires that the death certificate be exwirthin 24 hours after death. To the Funeral Directors After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pr 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnand Other (specify)	су		23d	. Date of delive	ery Day Year
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ne law req ite has bee iage 2 shou	Completed by	hypertiens hypertiens	en.a				24a. Was auto perfo 1 🔲 Yes	psy ormed?	prior to col death?	osy findings available mpletion of cause of
clan: 1	Be	25. Was case referred to medical examiner?	Hospital:			lace of Death (Che		2 No	i 🗀 ies	2,110
ding Pnysith.	욘	1 ☐ Yes 2 No 27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	1 ☐ Inpatient 28a. Date of injury (Month, Day, Yea	2 ER/Outpatient 28b. Time of injury					1	
ral or Atter rs after dea al Director ed in by the	Il Certificate:	3 Suicide 6 Could not be 4 Homicide determined			et, factory, office		28f. Location (S City or Tow		mber or Rural	Route Number,
tne Hospii hin 24 hour the Funera	Medical	(Check 2 ☐ Medical Exami only one) 3 ☐ Certifying Nurs	sician: To the best of my k ner: On the basis of examing the Practioner: To the best	nation and/or investi	gation, in my opinic eath occurred at th	on, death occurred a e time, date and pla	at the time, date a	and place, and	due to the cau	use(s) and manner state
Zo Wit		29b. Signature and title of certifier	-01	mo	29c. License	110-	-	1 .	gned (Month, I	
454		30. Name and address of person who of Mark DPh. It ps	ompleted case of death	(Item 23a) (Type, Pr	ells a	honce k	20 Ed.	rewate	er M	2010 D 21037
Stat Registra		31. Date filed (Month, Day, Year) APR 2 7 2	32. Régistrar's S	ignature .	ares					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 04 07:10 AM Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Shadyside 4937 Bonniewood Drive Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months 215 98 1470 1 □ M 2 😿 F Hours Jan 20, 1965 Maryland Director 45 Usual Residence of Decedent show iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes XX No Maryland Anne Arundel Shadyside 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4937 Bonniewood Drive 20764 United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. þ 1 Never Married 2XX Married 1 Yes 2 No If Yes, Give XX Baltimore, Maryland 21215-0036 1 Yes YY No Specify. Specify: White 3 Widowed 4 Divorced "natural" Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) 10th College (1-4 or 5+) P.G. County School Satalite Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lucille Hutchinson Charles David Rice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Collins (Husband) 4937 Bonniewood Drive, Shadyside, MD 20764 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department or Important: If any injury or 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ō Maryland Veterans Cemetery May 4, 2010 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Sig ur, of uneral Service ansec 22. Name and Address of Facility Lee Funeral Home. Inc 6633 Old Alexandria 96 Ferry Road, Clinton, MD 20735 ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock. lure. List only one cause Immediate cause I inal Physician/ ancer condition disease of Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a nonsectionne of if the Leading to in mediat cause. Enter Underlying executed Cause (Disease or iinjury burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ µ 9 ☐ Unknown 9 Unknown been signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform Director: After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 KR10 မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours after To the Funeral Dire City or Town, State) Medical 29a, Certifie Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 3 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

2

29a. Certifier

(Check

Director

Funeral

Completed by

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Physician/Medical Examine

Physician/

Medical

Examiner

Funeral Director

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For State Registrar		2.3.0 011	jiaila	•	tificate of l	Health and N Death		Reg. No.2	n	14821
1. Decedent's Nam	e (First, Middle, La	est) CHAMB	EDC				2. Date of Dea	th		3. Time of Death
LARRY							APRIL	21 201	ear 0	3:38 P M
		re street and number				Location of Death		4c. County of		
		HOSPITAL			CHEVE			PRINCE		
Social Security N 578-68-4 Juan Residence of	924	Sex 7.7 1 X M 2 □ F	Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day AUG 23	1950	Birthplac Country WASHI	ce (State or Foreigr NGTON, DC
Da. State	10b. County		10c. City,	Town or Loc	cation				10d	I. Inside City Limits
DC			1	WASHI	IGTON					1 ¥ Yes 2 □ No
e. Street and Nur	nber	-		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10f. Zip Code			10g. Citizen of Wh	at Country	?
6117 DI	X STREET	N.E.				20019		USA		
Marital Status		12. Was Deceder	t Ever in U.S.	13. V	Vas Decedent of H	ispanic Origin? (Spe	cify Yes or No-	14. Race -		
	ried 2 Married	Armed Forces	X No		Yes 2 X No		Rican, etc.)		White, etc	.ACK
3 Widowed	4 Divorced	If Yes, Give Year or Dates		,	LIYes Z ZAINO	ъреспу:		Specify:	DI	ACK
(Spe	15. Decedent's ecify only highest g			(Give I		during most of worki	ng	16b. Kind of Busin	ness Indus	stry
Elementary/Sec	onday (0-12)	College (1-4 o	r 5+)	life. DO	O NOT use retired)			0011=01=	(T):-	
	TH			PERS(ONAL ASSI			GOVERN	MENT	
177	First, Middle, Last) HAMBERS					18. Mother's Name				
								EILL		
ga. Informant's Na ELIZABET	ame/Relationship (Iype, Pant) ERS/MOTHE	_R			and Number or Rura ROAD SEAT				
a. Method of Disp					sition (Name of					
1 🄀 Burial 2	☐ Cremation 3	Removal from Sta	te cer	netery, cren	natory or other plac	ce)	Date	20c. Location - Ci		
_	5 Other (Spec		CEDA		CEMETER	1 1/ = 2/		SUITLAN		
. Signature of Tu	neral Service Licer	isee			Name and Addre	SOVER ROAD		NKINS FUI ER,MARYL		20785
3a. Part 1. Enter t	he disease, or con	nplications that caus one cause on each I	ed the death.	Do not ente	r the mode of dyir	g, such as cardiac c	r respiratory arre	est,		pproximate terval Between
nmediate Cause	(Final		IAC_ARI	מנידעות	Λ Τ Λ					nset and Death
esulting in death)	•		s a conseque		11A				+	
		END	STAGE I	RENAL	DISEASE					
sequentially list co any, leading to in	nmediate	Due to (or a	s a conseque	nce of):						
ause. Enter Unde Cause (Disease or hat initiated event	iinjury	C								
esulting in death)		Due to (or a	s a conseque	nce of):						
	•	■ d								
SELVAL S.										
FEMALE: 3b. Was decedent		23c. If yes, outcom			Ectopic pregnanc	***		23d. Date of	of delivery	
in the past 12 1 Yes 2		4 🔲 Pregnan	at time of dea		Other (specify)	,у		Month	Da	ay Year
9 Unknown		9 Unknow								
art II. Other signif	ficant conditions	contributing to death	but not result	ting in the u	nderlying cause gi	ven in Part I.	23e. Did tol	oacco use contribu	ite to the o	cause of death?
							1 🗆 Y	es 2 🗆 No 3	☐ Probab	oly 4 X Unknown
							24a. Was a		e autopsy	findings available
							autops perform 1 Yes	med? dea	th?	letion of cause of
. Was case referr	ed to medical				26 D	ace of Death (Check		2 № No 1 L	Yes 2	∆ No
examiner?		Hospital:	atient 2 K El	D/O::+-::	100	er:				
7. Manner of Deat	<u> </u>	1 ∐ Inpa 28a. Date of ir		R/Outpatien 8b. Time of	t 3 L DOA 28c. Injur	4 ☐ Nursing Ho		ence 6 Other (Some of the control of	specify)	
1 X Natural	5 Pending	(Month, E		injury	work	? Yes 2 □ No	.ca. Describe NO	m injury occurred		
2 Accident 3 Suicide	Investigation 6 Could not	be 380 Place of I	niun/ - At hom	e farm etra			ORF Location (Ct	root and Number -	r Dural D-	nuta Mumbar
4 Homicide	determined	28e. Place of I	njury - At hom etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (St. City or Town	reet and Number o	r Rural Ro	ute Number,

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D27577

29d. Date signed (Month, Day, Year)

APRIL 24, 2010

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Certificate: To Be Completed by

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CUMBERBATCH M.D. 3001 HOSPITAL DRIVE CHEVERLY, MARYLAND 20785

OPHNELL A.

31. Date filed (Month, Day, Year) APR 2 8 2010

1**X**

29b. Signature and title certifier

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 25, 2010 3:15 P Mary Elizabeth Cannizzo April 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Potomac Valley Nursing Center Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Pear March 8, 1 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 🗓 F 122-12-2025 95 1915 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20855 16721 Bethayres Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☑ Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Leather Seamstress Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walenty Kolodziej Cecilia Benedict 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16721 Bethayres Road, Derwood, MD 20855 Barbara C. Carrington/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 26, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Alexandria, VA Crematory 21. Signature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dementia Due to (or as a consequence of): Alzhheimers Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

Physician /Medical Examiner

physician and s the burial-tran

attending p

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funeral director,

After this

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ie Hospital or Attenomis in 24 hours after death. the Funeral Director: Aft

To the within 2 To the I

Physician/Medical

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Completed

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Certification: To

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Physician: The law requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

Physician

/Medical

10a. State

Examiner

Funeral

Director

'natural", or items 23a or 28a-f show dical Examiner must be notified at

Directo

Funeral

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Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Health and Mental Hygiene. tem 27 is marked other than "natur other traumatic event, in e Medical

permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last

autopsy performe 1 ☐ Yes 2 XNo

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 XNo 27. Manner of Death

1 🕅 Natural

2 Accident 3 Suicide

(Check only one)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

and manner stated

28b. Time of

Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a. Certifier

Hospital:

1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number D0056345 29d. Date signed (Month, Day, Year) April 26, 2010

Piyush Patel M.D., 19745 Executive Park Circle, Germantown, MD 20874

State Registrar

31. Date filed (Month, Day, Year) 27 2010

5 Pending

investigation

6 ☐ Could not be



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2<u>010</u> Physician/ Ida 24. Cohn April 10:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 ▼ F Months 1172871913 96 Director 110-07-1730 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director NY ty∟ Yes 2 ☐ No Oueens Flushing 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 143-07 Sanford Avenue, Apt. 11355 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give "natural", or Completed by 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 Yes 2X No Specify: 3 ₩ Widowed 4 □ Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 12 <u>Homemaker</u> Be and 2 should be filed Fleat Health and Mental Hw 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Samuel Schneider Fannie Schrager traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Carol Wallach, daughter 248 Washington Avenue, Tappan, NY Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverside Cemetery 04/27/2010 Signature of Funeral Service Licensee 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
11170 Rockville Pike, Rockville, MD 20852 MO1255 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final CEREBRO Onset and Death Physician/ disease or condition resulting in death) VASCUL Medical Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence on). attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Pregnant at time of death Day Year 1 ☐ Yes 2 № 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 23e. Did tobacco use contribute to the cause of death? Completed by PULMONARY DISEASE OBSTRUCTIVE 1 Yes 2 No 3 Probably 4 Unknown tor: After this certificate has been si the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death heck only one) Hospital: 2 No Other: ပ္ 1 Tes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending s after death. 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di Medical 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) MO 00061096 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar ISHA

6121

Registrar's Signature

MDNTROSE

ROAD, ROCKVILLE

GOLLAPALLI

68760 Box P.O. Records, of Vital or Attending Physician: To the Hospital or Attending within 24 hours after death.

To the Funeral Director Aft. Complet. d filled in by the fun Division

Maryland 21215-0036

Baltimore,

Certificate: Medical

Other: 4 \(\sum \) Nursing Home 5 \(\frac{\text{K}}{2}\) Residence 6 \(\sum \) Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Fractioner: To the best of my knowledge, death or

29b. Signature and title of certifier allet TAllas

MD D0055522

29d. Date signed (Month. Day, Year)

April 19, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert H. Gerard, M.D., 1500 Forest Glen Road, Silver Spring, MD 20910

Registrar

81. Date filed (Month, Day, Year) 26 2010



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Math 20 mean Lou Ann Coblentz 4:45 РМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Frederick Frederick Frederick Memorial Hospital Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 216-66-1907 1 M 2 TF Months Hours Min Nov. 12. 1956 53 Director Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Frederick Jefferson 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? 4320C Cherry Lane Funeral 21755 USA items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. than "natural", or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Divorced 4 Divorced Specify: White Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Homemaker Own Home permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygie Important: If item 27 is marked other any Injury or other traumatic event ** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Claude Jimmy Lewis Gloria Caroline Suck 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4320B Cherry Lane, Jefferson, Maryland 21755 Jackie Ratliff/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Cemetery, crematory or other place)
Hagerstown Crematory May 10,2010 Hagerstown, Maryland 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) e Licensee 504 Main Street Signature of Fi 22. Name and Address of Facility Ricketts Funeral Home Myersville, MD 21773 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ anc disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury use as the bunial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy jo Month Day Year Pregnant at time of death 5 Other (specify) completed filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed: 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Tes မ 1 Natient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Suicide Investigation within 24 hours after deal To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 0 29d. Date signed (Month, Day, Year) 5 2010 MDD 35106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nam 400 W 7th 5t Frederick MD 21701 Myuna Hee 31. Date filed (Month, Day, Year) **12 2010** State egistrar's Signature Registrar

DHMH 17 Rev 7/2009

JK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene state are from Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year AME 7:30 AM arter 2010 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death North Bentz St Frederick 600 Apartment If Under 24 Hrs. MI 5. Social Security Number 6. Sex **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **№** M 2□F Days 231-38-5917 Director March 26, 1935 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinar must be notified at anones. 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Frederick 1 ∏Yes 2 ☐ No Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 600 North Bentz Street 21701 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farmer Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Edward Carter 2 Ruth Anna Mauck 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Carter / Wife 600 North Bentz Street, Frederick, Maryland 21701 20b. Place of Disposition (Name of Camptery crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4/27/2010 4 ☐ Donation 5 ☐ Other (Specify) Ada, Virginia 21. Signati re of Funeral Service Libensee ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 201 NORTH MARKET STREET, FREDERICK, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): 01/20/2010-Examiner LUNG CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 4/23/2010 Due to (or as a consequence of): Examine that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year signed by the a 5 Other (specify) ☐Yes 2☐No o 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records. 23e. Did tobacco use contribute to the cause of death? 2 The law requires page 2 should Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 **N**0 1 □ Yes 1 Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the ft. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) the 29b. Signature and title of certifier 29c. License number D22567 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cau'e of death (Item 23a) (Type, Print) Westminster MD Vimala Naganna 700 A 31. Date filed (Month, Day, Tear) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

APR 26

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 2258 Joyce Elaine Couden Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ceci1 3912 Telegraph Road E1kton Social Security Number Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months $J_{uly}^{(Month, Day, Year)}$ 1949 Maryland Director 217-58-5228 60 Usual Residence of Decedent or items 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho appropriant: If item 27 is marked of other than "natural", or items 23a or 28a-f sho ampropriant: If item 27 is marked of other than "natural", or items 25a or 28a-f sho in injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No North East Maryland Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 46 Third Street 21901 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Completed by 1 Never Married 2 Married Yes Yes 2 X No 21215-0036 1 ☐ Yes 2 🔀 No Specify 3 ☐ Widowed 4 🏋 Divorced White Year or Dates 0 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) In Her Own Home Homemaker Be 17. Father's Name (First, Middle, Last) aryland 18. Mother's Name (First, Middle, Maiden Surname) ည Arnold Hill, Sr. Peru Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Danny D. Hill/Brother 1122 Cooks Lane, Baltimore, MD 21229 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gilpin Manor Date 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State May 4 ☐ Donation 5 ☐ Other (Specify) 2010 Elkton, MD Park 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hicks Home for Funerals, 21921 Stockton 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Ovarian anc Medical Due to (or as a consequence of) Examine Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) use as the burial-transl Hospital or Attending Physician: The law requires that the death certificate be execute attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown sate has been signed by the page 2 should be detached 1 Yes 2 J Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼ No 24a. Was an After this certificate has I autopsy within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, Cousin 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature e and address of person who completed cause of death (Item 23a) (Type, Print) State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 State FFMGRAInd 1686 APHent JH Health and Mental Hygiene 2010 Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **2010** Maÿ Mary Proud Cassidy 9:30 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 802 McLendon Drive Frederick Frederick **Funeral** \$78 S441 9080 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours 1 M 2 F 76 May 13, 1933 Washington DC Director Yrs Usual Residence of Decedent or 28a-f show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?

United States of America Completed by Funeral 21702 802 McLendon Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Midowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/S econday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Elvus Wayne Proud Genevieve McGuigan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Porreco / Daughter 239 East Second Street, Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Mount Olivet Cemetery May 7, 2010 Frederick, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Serving Keeney & Basford P.A. Funeral Home MO1433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ OBSTRUCTIVE PULMENARY CHRONIC Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Gertifying Nurse Practioner: To the best of my knowledge, death 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) D31761 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOI W. SEVENTH ST. 21701 0

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show Baltimore, Maryland 21215-0036

Physici /Medic Exami

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the timened director and 2 should be detected by the director and the first of the physician and completely filled in by the timened director and 2 should be detected or see the burief transfer. Division of Vital Records, P.O. Box 68760,

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Department of Health ar Important: If item 27 is any injury or other trau		21. Signature of Funeral Service Licenson	_ M00957	22 Name and Address of Going Home (Beverly L. H	rematio Heckrott	n Service e, P.A. (e P.O. Box Clarksvill	k 784 le, MD 21029		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 4-Physician/ Samuel Wesley Doane, Medical a. Facility Name (if not institution, give street and number **Examiner** 4c. County of Death 8. Date of Birth (Month, Day, Year) Jan. 28, 1932 7. Age (In yrs. last birthday) If Under 1 9. Birthplace (State or Foreign Funeral 1 X M 2 □ F Hours Maryland Director 78 214-28-1304 Usual Residence of Decedent 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 ื No Somerset Marvland Westover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21871 USA 30093 Fairmount Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1X Yes 2 □ No If Yes, Give Year or Dates. 1954 1 Never Married 2 X Married 21215-0036 1 ☐ Yes 2 🗓 No Specify Specify: Black Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Farming laborer 7th Be **Baltimore, Maryland** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Adrena Samuel Henry Doane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30093 Fairmount Road - Westover, MD 21871 Catherine W. Doane/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 04/26/2010 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, Maryland 22. Name and Address of Facility 1213 Jersey Road, Salisbury, MD 21. Sig/tu 21801 JOLLEY MEMORIAL CHAPEL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death CARCINDUNA Physician/ MRTASTA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events ng physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 24 hours after death.

• Funeral Director: After this certificate has been signs letted filled in by the funeral director, page 2 should be a 2 No 3 □ Probably 4 □ Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 2 No မ 1 🗌 Yes HOSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending 1 Yes 2 No М Accident Investigation To the Hospital or Atter within 24 hours after dec To the Funeral Director completed filled in by th Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier 29b. Signature 29d. Date signed (Month, Day, Year, 00058410 4111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VF BU 70 Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#26 per PHY State of Maryland / Department of Health and Mental Hygiene

State 4/28/10 AACO HEALTH DEPT. CMH Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month4/21/29010 Bonnie Alma Dunn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center Social Security Number If Under 1 Year If Under 24 Hrs Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 KM Days 64 Months Hours 220-54-2155 3/19/1948 Director Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location Director ms 23a or 28a-f s must be notified MD Anne Arundel Harwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4583 Owensville Sudley RD. 20776 er than "natural", or items the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ۾ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XXNo Specify: Completed 3 ▼Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Naturalist Education other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James Earle Dixon Alma Beall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Owensville Sudley RD. Harwood, MD 20776 Kathleen Bjerknes Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I-Important: If ite any injury or ot 1 Burial 25 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4/21/2010 Atlantic Crematory Glen Burnie, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ar fern Physician/ disease or condition resulting in death) COYONGVY Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death signed by the at d be detached for ☐ Pregnam
☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 X No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The 24 hours after death. Funeral Director: After this certificate by Funeral Director: After this certificate by Funeral Directors. Division of Vital funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 ☐ Yes 2 🔼 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Matural 5 \square Pending injury work? 1 ☐ Yes 2 ☐ No. Accident Investigation the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) April 21, 2010 038563 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3. Time of Death

0353

9. Birthplace (State or Foreign

USA

White

Approximate

Dav

2 No

1 Yes

West River, mo 20778

Interval Between Onset and Death

4eg-s

DC

10d, Inside City Limits

1 ☐ Yes 🎗 🔽 No

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 2 8 2010

		For	Please	Type or Pri State of M		d / Depa	artment of	Health and	-		_	
		1 - State Registrar				Ce	rtificate of	Death		Reg. No.	201	0 11.83
Physicia /Medic		James	e (First, Middle, La Edward	,					2. Date of De Month	Day	Year 2010	3. Time of Death 2:26 P
Examin		4a. Facility Name (/	If not institution, gi	ve street and number)		4b. City, Town,	or Location of Deat	h	4c. (County of Deat	
. 		Frederic	k Memori	al Hospita			Frede				Frederi	
Funeral Director		5. Social Security N 219–14–5		Sex 7. A 1 🔀 M 2 🗆 F	ge (In yrs. 84	last birthday) Yrs.	Months Days		8. Date of Bir (Month, Da 6/20/	th 1925 1925	9. Birt Co Mar	thplace (State or Foreign ountry) Yland
pu.		Usual Residence of 10a. State	f Decedent 10b. County		10c Cit	y, Town or Lo	nation					10d. Inside City Limits
aryla sho	٦ ا											172 Yes 2 □ No
the N	Director	MD 10e. Street and Nur	Frede	rick	Br	runswic	10f. Zip Code		T	10a Citi-	zen of What Co	**
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eath	Funeral	209 Ea	st A S	treet 12. Was Decedent	Ever in U.	S. 13	2171 Was Decedent of	Hispanic Origin? (S	Specify Yes or No	n- 1	USA 14. Race - Ame	erican Indian
ter d	듄		ied 2 5 Married	Armed Forces	?	0. 10.	If Yes, specify Cu	ban, Mexican, Puerl	to Rican, etc.)	, I	Black, White	
at yieling Z.I.Z.13-0030 should be filed within 72 hours after death with the Maryland ind Mental Hygiene. In marked other than "natural" or items 23a or 28a-f show umatic event, it a Modical Examinar must be notified at	ρ	3 🗆 Widowed		1 √Yes 2 ☐ If Yes, Give Year or Dates:			1 ☐ Yes 2 No	Specify:			Specify: Wh	nite
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thin 7	ple	Elementary/Seco	cify only highest gr andary (0-12)	College (1-4or	5+)	life.	DO NOT use retir	e during most of wor ed)	rking			
d wil	Completed	12				Engir	neer				ilroad	
an yianto K. I.K. should be filed with and Mental Hygiene. is marked other than aumatic event, the Mental Control of the Mental Cont	Be	17. Father's Name	(First, Middle, Las	t)				18. Mother's Nar	ne (First, Middle	, Maiden S	Surname)	
Men Men arke	၉	James E	Dyer					Ulva Wh	<u>ite</u>			
		19a. Informant's Na				19b. Maili	ng Address (Stree	et and Number or Ri	ural Route Numb	er, City or	Town, State, 2	Zip Code)
ie, wall yiallia 21213-0030 stand should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if Health and Mental Hygiene if the marked other than "natural" or Items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at		Virginia		Wife				reet, Br			21716_	
Pages 1 and 2 ment of Health and 2 ant; If item 27 is ury or other tra		20a. Method of Disposition 12 Burial 2		☐ Removal from State			osition (Name of matory or other pla		Date		cation - City or	
t. Pa tmen tant;		4Donation	5 ☐ Other (Spec	ify)	Hil		Burial Parl		/2010	Curibe	rland M)
permit. Pages 1 and 2 Department of Health of Important: If item 27 is any injury or other tra		21. Signature of Fu	uneral Service Lice	7. Willia	ond		2. Name and Addi John T Will	ess of Facility Liams Funera	al Home. E	Brunsw	ick MD 21	1716
		23a. Part 1. Enter t	the disease, or cor	nplications that cause	d the death							Approximate
Physician		Immediate Cause	(Final	one cause on each I	ine.	4 -		ONE DESCRIPTION AND DESCRIPTIO				Interval Between Onset and Death
/Medical		disease or condition resulting in death)	on 📶	a. Due to (or	a consen	ueno« of):	1 PM	UUNON	ua			s cay
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ecuter nd transi	Examiner	Cause (Disease or that initiated events	injury	c	MM	1	and	i coas	16/1	S		
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leath certificate attending physic	Me	IF FEMALE:		OGO If you guitage				,				
attenc for us	ian/	23b. Was decedent in the past 12		23c. If yes, outcome	2 🗆 Feta	I death 3	Ectopic pregnar	ncy		2	23d. Date of de Month	livery Day Year
Attending Physician: The law requires that the death certificate sr death. Attending Physician: The law requires that the death certificate ector: After this certificate has been signed by the attending phys by the funeral director, page 2 should be detached for use as the	Physician/Medic	1 □Yes 2 [9 □ Unknown		4 ☐ Pregnant : 9 ☐ Unknown	at time of d	ieath 5L	Other (specify)					
that the the perfect of the perfect		Part II. Other signif	ficant conditions	contributing to death I	out not resi	ulting in the u	nderlying cause g	iven in Part I.	23e. Did	tobacco u	se contribute te	o the cause of death?
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ding Ph th. : After th e funeral	흝	1 ☑ Natural 2 ☐ Accident	5 Pending investigation	(Month, D.	ay, Year)	Injury		ork? ⊒Yes 2.⊡No				
Atter	ij	3 ☐ Suicide 4 ☐ Homicide	6 Could not I	28e. Place of In	jury - At ho	ome, farm, str	reet, factory, office					ural Route Number,
tal or rs afte al Dir	Certification:	4 🗆 Holflicide	/							wn, State)		
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier (Check only one)	1 ☑ Certifying P 2 ☐ Medical Exa	hysician: To the best miner: On the basis and manner s	of examina	wledge, deat ation and/or in	th occurred at the ovestigation, in my	time, date and plac opinion, death occ	e, and due to the urred at the time	e cause(s) , date and	and manner a l place, and du	s stated. e to the cause(s)
To the vithin To the comple	Med	29b. Signature and	title of pertifier	and manner s	arva.		29c. Licer	nse number		29d. Dat	te signed (Mont	th, Day, Year)
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,_	}	30. Name and addr	ress of person who	completed cause of	death (Item	n 23a) (Type,	Print)	1		7	1	.212.
10		Hejo	1 A73	low six	MAN	14	75 7	any c	M (fu	deric	1 Rep 121
Stat	-	31. Date filed (Mon	ith, Day, Year)	32-Regist	rar's Signa	iture	darken	(1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 24 Day 2010 ear 4:00 p Frances Marie Dapolito Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. 1 🗆 M 2 F Months Hours Jan. 13, Year 1924 D. Country) Director 578-32-2880 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the Marker. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland P.G. Adelphi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20783 USA 3210 Powder Mill Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. þ Specify: White 1 Never Married 2 Married े Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛂 No Specify: 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clerical Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ George Crouch Florence Sauber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13419 Crispin Way, Rockville, MD 20853 19a. Informant's Name/Relationship (Type, Print) George A. Dapolito/Son April 2010 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 28 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service Licensee

22. Name and Address of Facility ins Funeral
500 University Blvd. W., Si

23a. Part 1. Ever the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Home Silver Spring, MD 20901 Approximate Interval Between Immediate Cause (Final Physician Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of):
Respiratory Failure **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence oi) ed by the attending physician and detached for use as the burial-transit executed Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Year Day 5 Other (specify) Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>à</u> Diabetes Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No Yes 2x No funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1X Natural 5 Pending 1 Tes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate it npleted filled in by the 0

29a. Certifier

only one) 29b. Signature and title of certifie

1500 Forest Glen Road, Silver Spring, MD 20910 Kshama Garg, 31. Date filed (Month, Day, Year, 32. Registrar's Signature rached. State APR 26 2010 Registrar

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Prijstolani. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

d60826

29d. Date signed (Month, Day, Year) April 25, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 04/20/2010DOROTHY NICHOLS DELAWDER М 2215 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Montgomery Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours Min. 09/30/1929 Director 578-48-1043 80 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Rockville MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20853 **USA** 13107 Hallet Court hours after death 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. ð 1 Never Married 2 Married Yes Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Specify: White "natural" Completed 3 Widowed 4 XDivorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland 5th Daycare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ William Elmer Norris Daisy Hyancinth Christ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13107 Hallet Court, Rockville, MD 20853 Robert Byram - son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from St Ardent Cremation Sv 4/23/10 Hanover, MD 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service License 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disea se, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Acute respiratory failure disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Pneumonia Sequentially list conditions Examine Due to for as a consequence of If any leading to immedia cause. Enter Underlying Cause (Disease or iinjury law requires that the death certificate be executed use as the burial-transit Congestive heart failure and that initiated events Due to (or as a consequence of) physician Physician/Medical Pulmonary hypertension Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ō Month Pregnant at time of death 5 Other (specify) the g 9 Unknown P.O. ed by t signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes mellitus Division of Vital Records, 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available 24a. Was an Hypertension Jas page 2 prior to completion of cause of autopsy perform death? Hospital or Attending Physician: The 124 hours after death. Funeral Director; After this certificate heted filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ပ 1 XInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🕅 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours aff

To the Funeral Di

completed filled in Medical 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contributing Number Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as also contributed.

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

V. Ganti, MD

31. Date filed (Month, Day, Year) APR 2 6 2010

To the

10

19529 Doctor's Drive, Germantown, MD 20874

29c. License number

D41162

29d. Date signed (Month, Day, Year)

4/21/10

Gertifying Nurse Practioner: To the best of my knowledge, death

zanti mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2 1 Day Physician/ April April 2010 Year 6:38 ам Hung Thieu Duong Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c, County of Death 3804 Park Lake Drive Rockville Montgomery 5. Social Security Number Funeral 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Vietnam 1 🗓 M 2 🗆 F Months Hours Min. 09/15/1930 **Director** 586-42-6986 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Maryland Montgomeru Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3804 Park Lake Drive 20853 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 ☐ Widowed 4 ☐ Divorced If Yes. Give Completed Specify: Asian Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **5**+ Colonel Vietnam Military Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Dhong Tu Duong Chi Dhi Nguyen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Phi Hong Duong - Son 113 South Linwood Avenue, Baltimore, Maryland 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 💢 Cremation 3 ☐ Removal from State Lincoln Crematory 04/26/2010 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee NA 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Hepatocellular Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death signed by the a d be detached f 1 Yes 2 L 9 Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 🛛 No 3 🗌 Probably 4 🗌 Unknown Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law autopsy page performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🛛 Residence 6 🗆 Other (Specify) ပ 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 Pending 24 hours after death Accident 1 Yes 2 No Investigation 6 Could not be completed filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | Medical Examiner: On the basis of examination and/or investigation, in rily opinion, usati occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Box 68760 P.O. Records, **Division of Vital** To the I within 2

> State Registrar

29b. Signature

2nd title of certifier

Arthur Schoengold,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD.

37. Registrar's Signature

29c. License number

D18726

18111 Prince Philip Drive, #T-10, Olney, Maryland 20832

29d. Date signed (Month, Day, Year)

April 21, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 00 SANDRA S. DICK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner ALLEGANY** W. MD, REGIONAL MEDICAL CFNTER CUMBERLAND If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🛣 06/07/1943 215-42-4895 Maryland Director 66 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 1X Yes 2 ☐ No Cumberland Allegany MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be Funerai 21502 U.S.A. 550 N. Mechanic Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: White 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Medicine Medical Transcriptionist Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic eveniany. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ (Unknown) Charles Dick Susan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry W. Merkel, Jr./Friend 21502 550 N. Mechanic Street, Cumberland, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Cumberland Crematory 02/01/2010 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Lio Upchurch Funeral Home, P.A. 202 Greene Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Metastatiz Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) ending physician and use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy 3 Year Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an • Hospital or Attending Physician: The law 1 24 hours after death.
• Funeral Director, After this certificate has b autopsy 2 No 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🔁 No Hospital Other: မ 1 Tes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? ë 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending Certifical 1 Yes 2 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier 🕍 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 30 Name and address

Beverly Cal

500 Memorial Avenue, Cumberland, MD

of person who completed cause of death (Item 23a) (Type, Print)

Regis

ar's Signature

Calkins, M.D.,

01/26/10

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year APRIL **Physician** 5:50 AM DIETERILH NILDRED MAE 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** KAVENWOOD HAGERSTOWN WASHINGTON If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** Months 1 □ M 2 🔽 F Yrs. 214-09-9633 93 Feb. 9, Maryland Director 1917 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at 1 X Yes 2 □ No Director MT Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 512 S. Cannon St. 21740 Funeral U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🌠 No Specify: Specify: White δ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Aircraft Elementary/Secondary (0-12) College (1-4or 5+) Clerical Manufacturing permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important; if item 27 is marked other than yi injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည William Statton Bowman Daisy Elizabeth Shildneck 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Herchenrother/Daughter 334 Yorkshire Dr., Hagerstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 5/11/2010 Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Anterio Scherchia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit one publicately. Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month 5 Other (specify) P.O. | 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>6</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Diht Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 100 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a, Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number att mo APRIL 29, 2010 D0018019

State Registrar 31. Date filed (Month.

HACERSTOWN MD 21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

340 Mill

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year JOP M Bettv Drummond Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frostburg 19 Green Street Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) MD 8. Date of Birth **Funeral** Months Days Hours 190V 4 2 ¹1922 218-16-4540 Director 87 Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must han material. 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Funeral Director MD Allegany Frostburg 1 XYes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 19 Green Street 21532 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify: white Completed 3 - Widowed 4 - Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sacred Heart Hosp. retired nursing assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Walker Estelle (Winters) Walker Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 19 Green Street Frostburg MD 21532 John Drummond husband 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 5/7/2010 Frostburg Memorial Park MD Frostburg 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Se 22. Name and Accipe if Full Yeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a, P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ate has been signed by the atterpage 2 should be detached for u in the past 12 month Year Pregnant at time of death Unknown Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ BETES MELLI Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of YPERTENS(O) 24a. Was an autopsy performed Yes 2 death? this certificate 2 No within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director. 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 1 Inpatient 2 Inpatient 3 Inpotent 2 Inpatient 3 Inpotent 2 Input Environment 2 Input 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date 30. Name and addres s of person who completed cause of death (Item 23a) (Type, Prin 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Genera Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** Dassens Davus 11-44 AM 6 IC /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood @ Crumland Farms Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct 22, 19 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F 216-14-5280 87 Yrs. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at Maryland Frederick Frederick 1X Yes 2 No **Funeral Director** 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ms 23a or 7 7407 Willow Road 21702 U.S.A. item 27 is marked other than "natural", or Items 23a other traumatic event, the Medical Examiner must b 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2X No Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Telephone Operator Communications 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Edward Davis Grace Elizabeth Lambert George 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Alice Marks, Sister 7401 Willow Road, Unit 310, Frederick, MD 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State j-1 Burial 2 □ Cremation 3 □ Removal from State ō Mt Olivet Cemetery May 8, 2010 Frederick, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Line ²², Name and Address of Facility
Keeney & Basford P.A. Funeral Home 106 E Church St, Frederick, Maryland 21701 ✓M00706 23a. Part 1. Enter the rease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart foliume. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performe page 2 2 **N**o certificate 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 ☐ Inpatient 27. Mann of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAJJAD AZIZ, MAN One 32. Registrar Signat State Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRTT. 2 Day 2010 JOYCE LEE DENNIS 8:27 \mathbf{P}^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPICE CENTER OF QUEEN ANNE'S **OUEEN ANNE'S** CENTREVILLE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8 Date of Birth Funeral 1 □ M 2 🗶 F Days Hours JUNE 74 1938 212-36-4456 71 MARYLAND Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, <u>the Medical Examiner must be notified at</u> 10a State 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND QUEEN ANNE'S 1 Yes 2 X No CHESTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2012 STEVENS DRIVE 21619 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) SECRETARY **EDUCATION** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ BENSON DEAN SARAH KELLY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 CHARLES K. DENNIS/HUSBAND 2010 STEVENS DRIVE, CHESTER, MD 21619 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State -APRIL 26 permit. Page 1 and Department of N CHESAPEAKETYCREMATION 1 Burial 2 X Cremation 3 Removal from State STEVENSVILLE, MD 4 Donation 5 Other (Specify) 2010 CENTER FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 21. Signature of Funeral Service Licenses Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a Part Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed g physician and strans Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? 1 Yes 2 Ectopic pregnancy Month Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No Yes 1 L Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 100 ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending injury 1 Diatural ___atural ☐ Accident ☐ Sui 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cert 3793C

DHMH 17 Rev 7/2009

State Registrar

30. Name and address of person

20-6 31. Date filed (Month, Day, Year) 175 (70mm

ho completed cause of death (Item 23a) (Type, Print) 2004

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 30 Day 2010 Year John William Dinterman, Sr. 5:00 PM M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8016 Fieldstone Drive Frederick Frederick Social Security Number Age (In yrs. last birthday, 73 Yrs. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Year 1936 1 ₹ M 2 □ F Months (Month, Day eC 28 217-32-6412 Days Hours **Director** Mary land Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick Maryland Frederick 1 Tyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 8016 Fieldstone Drive 21702 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify. Specify: White 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Owned and Operated Cleaning Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Clifford Dinterman Evelyn Nusbaum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John W. Dinterman, Jr., Son 104 Boswell Blvd., Smithsburg, MD 21783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Mount Olivet Cemetery May 4, 2010 4 Donation 5 Other (Specify) Frederick, MD 21. Signature of Pineral Service Licensee 22. Name and Address of Facility Keeney and Basford PA Funeral Home M00255 106 East Church St., Freder ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Frederick, MD 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 4 Nursing Home Sesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural Investigation 1 Tes 2 No Accident within 24 hours after deatl

To the Funeral Director..

completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D 16428 cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed

State Registrar Casper E.

Cline III, M.D., 300 West Ninth Street, Frederick, MD 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4842 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 2^{dy} 201^{oar} 12:30PM <u>Vanzago Demetric</u> Davis 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Upper Marlboro 209 Minnesota Way If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country)
Wash.D.C. 7. Age (In yrs. last birthday) 13 mth, 1 ★ M 2 □ F Months Days Hours Min Day, Year) 1955 Yrs 212-62-1546 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Upper Marlboro . G 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20774 U.S.A. 1209 Minnesota Way 12. Was Decedent Ever in U.S. Armed Forces? 1,984 If Yes, Give Year or Dates. 1987 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify: Black 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Instructor WMATA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Juanita Proctor Charles Davis Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Regina R. Rivers-Davis 1209 Minnesota Way Upper Marlboro, Md. 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Veteran's Cem. 5/3/2010 Cheltenham, Md. 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Hodges and Edwards Silver Hill Rd. Suitland, Md. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PANCREATIC Immediate Cause (Final CANCER disease or condition resulting in death)

Physician/ Medical **Examiner**

Physician/

Examiner

Funeral

Director

28a-f show

with the Maryland

within 72 hours after death

Baltimore, Maryland 21215-0036

items 23a or 28a-f shoner must be notified at

the Medical Examiner

"natural", or

and Mental Hygiene.

permit. Page 1 and 2 should be file Department of Health and Mental Important: If Item 27 is marked cany injury or other traumatic everones.

Medical

10a. State

MD

Director

Funeral

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Completed

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physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be execu-Division of Vital Records, P.O. Box 68760 attending p signed by the a 2 should has page certificate completed filled in by the funeral director, After this

Physician/Medical Examiner Completed by Be 10 Certificate:

	Toolang in doubly	Due to (or as a consequence of):						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c	Due to (or as a consequence of):						
	resulting in death) Last	Due to (or as a consequence of):						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		opic pregnancy er (specify)		23d. Date of de Month	livery Day Year		
	Part II. Other significant conditions con	tributing to death but not resulting in the underly	ying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?		
						robably 4 Nunknown		
				24a. Was an autopsy performed' 1 Yes 2	prior to death?	topsy findings available completion of cause of		
١	25. Was case referred to medical examiner?		26. Place of Death (Check	only one)				
	1 ☐ Yes 2 🛣 No	ospital: 1 Inpatient 2 ER/Outpatient 3	□ DOA Other: 4 □ Nursing Ho	me 5 Residence	6 Other (Spec	cify)		
	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury M	work?	28d. Describe how inj	ury occurred			
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ate)			
	(Check 2 Medical Examine	clan: To the best of my knowledge, death occurrer: On the basis of examination and/or investigation Practioner: To the best of my knowledge, death	n, in my opinion, death occurred at	the time, date and pla	ce, and due to the	cause(s) and manner stated		
	29b. Signature and title of certifier	11, 0	29c. License number	29d. [Date signed (Mont	h, Day, Year)		

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State Registrar

after death.

within 24 hours a To the Funeral D

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Degedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** SINger /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner olvege View Center Frederick GENESIS (If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🛣 F Hours 229-16-9781 90 Director Jan. 22, 1920 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Medical Examinating to mailfied a 10a. State 10b. County 10c. City, Town or Location Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 700 Toll House Avenue 21701 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 👿 No Specify. 2 3₺Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert H. White ဂ္ Ella G. Madigan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chris Ebersole / Son 415 Columbus Ave. Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) April 20. 1 ☐ Burial 2 X Crema 4 □ Donation 5 □ ther (Specify) Resthaven Crematory 2010 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. ral Service License 9501 Catoctin Mountain Hwy. Frederick, MD 21701 23a. Part 1. Enter the disease, or com shock, or heart failure. List only flons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line.

ardiomypipath

Due to (or as a consequence of):

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Physician /Medical **Examiner**

Immediate Cause (Final

disease or condition resulting in death)

Examiner physician and the burial-transit been sign should be

Physician/Medical þ Completed Be Certification: To

Medical

31. Date filed (Month, Day, Year)

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	Nosion	rccident								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 Ectopic preg			23d. Date of delivery Month D	/ lay Year					
Part II. Other significant conditions Vascular De		sulting in the underlying caus	se given in Part I.		use contribute to the ☐ No 3☐ Probal	- 1					
				24a. Was an autopsy performed? 1 □ Yes 2 □ No	prior to comp death?	y findings available bletion of cause of					
25. Was case referred to medical examiner?		26. Place of Death (Check only one)									
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 M Nursing Home 5 Residence									
27. Manner of Death 1 Manual 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)			8d. Describe how injur							
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		t and Number or Rural Route Number, tate)									
29a. Certifier (Check only one) Certifying F 2 Medical Example	Physician: To the best of my known aminer: On the basis of examinated and manner stated.	owledge, death occurred at a tation and/or investigation, in	the time, date and place, and my opinion, death occurred	nd due to the cause(s d at the time, date and) and manner as sta d place, and due to t	ted. ne cause(s)					
29b. Signature and title of certifier	1	29c. Li	icense number	te signed (Month, Da	signed (Month. Day, Year)						

R125360 4/20/2010

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 No Yes 2 No

Virginia

United States

14. Race - American Indian, Black, White, etc.

Specify: White

16b. Kind of Business/Industry

20c. Location - City or Town, State

Frederick, Maryland

Approximate Interval Between Onset and Death

<u>Retail</u>

2010

Frederick

4c. County of Death

10g. Citizen of What Country?

10pm M

Registrar

State

within 24 hours after deat To the Funeral Director:

completely

Barbara A. Naden-Blucher - 6095 Marshalee Drive, Elkridge, MD 21075

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 22, 2010 Year Physician John Frederick Ege 12:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll County 912 Uniontown Road Westminster WES LILLIS C...

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Nov. 3, Nov. 3, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Country)
Maryland 1 💢 M 2 🗆 F 218-34-1487 70 1939 Director Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 XYes 2 □ No Maryland Carroll County Westminster Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21158 United States 912 Uniontown Road Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 196 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 h (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Customer Relations Public Utility permit. Pages 1 and 2 should be filed will be partment of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other transmitted. 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be Frederic Ege Pauline Richards ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Ege / wife 912 Uniontown Road Westminster, Maryland 21158 Date 22 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) April Carroll Cremation Hampstead, Maryland 2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licenses M01072 934 South Main Street Hampstead, Maryland 21074 Turver 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause queach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician wears disease or condition resulting in death) /Medical (or as a consequence of): Examiner Fasely Sequentially list conditions, if any, reading to initionate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto for sela consequence off Examine executed Due to (or as a consequence of): burial-Box 68760, physician certificate be Physician/Medical the attending use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Year in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the Ö 9 Unknown 9 Unknown <u>a</u>. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an has page 2 autopsy perform res 2 certificate 1 TYes of Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🔲 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ္ this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Hospital or Attending Division 1 Natural 2 ☐ Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No n 24 hours after death.

Ne Funeral Director; A

bletely filled in by the fi 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical npletely and manner stated. To the I within 2 To the I complet 29d. Date signed (Month, Day, Year) 29b. Signature any 29c. License number WJL 3125 Baltimore Boulevard 30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print) 10 Finksburg, Maryland 21048

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Vincie Eveline Elmore 2010 Mav 12:03AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Manor Health Care Center Rising Sun Cecil Social Security Number 6. Sex if Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral g. Birthplace (State or Foreign Month, Day, 1 🗆 M 2 🔯 F Months Hours Min 220-80-5694 Director 97 Virginia 91 June Usual Residence of Decedent "natural", or items 23a or 28a-f shov idical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2X No Harford MD White Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2755 East Church Lane 21161 USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc Completed by 1 Never Married 2 Married 1 Yes 2 X No 1 Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates permit. Page 1 and 2 should be filed within 72 houn Department of Health and Mental Hygiene. Important. If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Isaac Spencer Ida Elizabeth Ingram 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2755 Spencer I.M. Elmore/Son East Church Lane White Hall, MD 21161 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May Date 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Dulaney Valle Timonium, MD Memorial 2010 Gardens Signature of Funeral Service Licensee 22. Name and Address of Facility J.J. Hartenstein Mortuary Inc. Stewartstown, S. Main St. 17363 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirat n shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) brovasci Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Dav Year signed by the a d be detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à law requires Records, cate has been signated bage 2 should b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed Hospital or Attending Physician: The certificate **≫** No 1 🗌 Yes **Division of Vital** director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 1 Natural injury 5 Pending Accident
Suicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Extifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29c. License number 29d, Date signed (Month, Day, Year, 4 and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day,

AY 1 0 2010

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

John Heaphy Fellowes State of Maryland / Department of Health and Mental Hygiene 2010 | 4846 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month Day 3, 2010 Medical Examiner John Heaphy Fellowes 1627 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. **Funeral** Country) NY Months Days Hours 11/22/1932 Director 77 526-30-5369 1X M Yrs Usual Residence of Deceden 10a State 10c. City, Town or Location 10d. Inside City Limits Annapolis MD 1 Yes 2 No Anne Arundel tem 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at once. Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21409 USA 3 Chase Rd. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 X Married White, etc. 1 Never Married Yes No 4 Divorced If Yes, Give Year Vietnam White 3 Widowed 1 Yes 2 No specify: Specify: <u>۾</u> imore, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) US Navy 4 Captain 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Elizabeth Evans Be Frederick G. Fellowes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annapolis, MD 21409 3 Chase Rd. Patricia Fellowes Wife Department of Health an Important: If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 5/14/2010 Annapolis, MD USNA Ponation 5 Other Specify. nature of Faheral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Ridgely Ave. Annapolis, MD 21401 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure/List only one cause on each line Between Onset and /Medical Death Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to for as a consecuence of). Examine if any liteding to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate be exceuted Physician/Medical been signed by the attending physician a hould be detached for use as the burial -X UNPENDED AMENDED 23a, PII, 27, per ME g903 5/14/10 TT IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Day Fetal death Month Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 ✓ Unknown Cirrhosis of liver Completed After this certificate has been s funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 🗸 Yes ✓ Yes 2 No 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 Other: Nursing Home 5 Residence 6 Other: 1 V Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Pending 1 Yes 2 No the Funeral Director: npletely filled in by the f Accident 2 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one) 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ED O.C.M.E. May 4, 2010 0 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Russell Alexander MD. 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month DVy, Year)) 32. Fegistrar's Signature State Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ Miam Kichard tenguson 2010 7:05 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death I och Raven Community Living Baltimore Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) 01/10/1930 1 X M 2 🗆 F 80 Months Days Hours Min. Country) New York 066-22-4449 Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director Anne Arundel Odenton 1 Yes 2 X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 510 Jo Ann Drive 21113 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give 47-67
Year or Dates. Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. "natural", Specify: White Completed 3 ♥ Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) GySgt US Marines other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Himportant: If item 27 is marked o any injuy or other traumatic eve once. ည William L. Ferguson Estelle Kowsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Ebersol Daughter 12 1st Ave Brooklyn, MD 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans 04/28/2010 Crownsville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Hardesty Funeral Home P.A. Gambrills, MD 21054 Tali 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final adder Carcinama Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): and I-transit Due to (or as a consequence of): resulting in death) Last -purialphysician s the burial Physician/Medical death certificate be P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 9 Unknown 2 🗌 No the 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24a Was an 24b. Were autopsy findings available To the Hospital or accession 24 hours after death.

To the Funeral Director. After this certificate has been accessed filled in by the funeral director, page 2. autopsy performed? Yes 2 No prior to completion of cause of death? 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: Hospice ည 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 27. Man r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work? Accident Suicide 1 🗆 Yes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number D4136 29b. Signature and title of certifier M 30. Name and address of person who completed cause of death (Igem 23a) (Type, Print) Loch Kaven Wicks

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Maryla Horions. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after clearh Division of Vital Records, P.O. Box 68760

		State of Maryland	/ Depa	artment of H	ealth and M		_	ible.			
		Registrar	Cer	tificate of D	eath	Re	g. No. 🥠	110	11011		
Physicia Medic		1. Decedent's Name (First, Middle, Last) Walter Henry Fryc				2. Date of Death April 2					
Examin		4a. Facility Name (if not institution, give street and number) Harmony Hall Assisted Living		4b. City, Town, or Location of Death Columbia			4c. County of Death Howard				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 2 78	birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth 03/22/19	(ear) 32	Count	ace (State or Foreign y) chusetts		
f show ed at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, T	own or Loc	cation					d. Inside City Limits		
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s 23a or lust be r	Funeral Director	10e. Street and Number 1202 Topaz Court		10f. Zip Code 21113	3	10	g. Citizen of W USA		ry?		
Department or health and Mental hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Section 195 If Yes, Give Year or Dates.	4- If	Vas Decedent of His Yes, specify Cuban Yes 2 XX No	Mexican, Puerto R	ify Yes or No- ican, etc.)	s or No- etc.) 14. Race - American Indian, Black, White, etc. Specify: White				
e. nan "natur e Medical	Completed		16a. Decedent's Usual Occupation (Give kind of work done during most of wo				6b. Kind of Bu				
ygien her ti	Be C			M/SGT			US Ar				
mental H arked ot atic ever	ToB	17. Father's Name (First, Middle, Last) Walter Fryc			18. Mother's Name (First, Middle, Maiden Surname) Helen Matuszak						
alth and n 27 is m er traum				g Address (Street an Topaz Ct.		Route Number, C	•	ate, Zip Co	ode)		
nt: If iten		1XX Burial 2 ☐ Cremation 3 ☐ Removal from State cem	etery, crem	sition (Name of natory or other place) Veterans			Oc. Location -				
Departing Importa any inju once.		21. Signature of Puneral Service Licensee	22.	Name and Address Annapol	of Facility Hard	lesty Fu	neral E	lome,			
sician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):									
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nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events c.	od 01):								
hysiclan ar the burial-t	ical	resulting in death) Last Due to (or as a consequence of the consequen	ce of):								
To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal de 4 ☐ Pregnant at time of dead 9 ☐ Unknown	eath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date Mor	e of deliver	y Day Year		
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or: After	Certificate:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be	b. Time of injury	28c. Injury a work? M 1 🗆 Ye	es 2 \square No	3d. Describe how	injury occurre	d			
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the Funer	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge only one) 3 Certifying Nurse Practioner: To the best of my knowledge only one) 1 Certifying Nurse Practioner: To the best of my knowledge only one) 1 Certifying Nurse Practioner: To the best of my knowledge only one) 1 Certifying Nurse Practioner: To the best of my knowledge only one) 1 Certifying Physician: To the best of my knowledge only one of the best of my knowledge only one of the best of my knowledge on the best of my knowledge of my knowledge on the best of my knowledge on the best of my knowledge of my knowledge on the best of my knowledge on the best of my knowledge on the best of my knowledge on the best of my knowledge of my knowledge on the best of my knowledge of my knowledge on the best of my knowledge of my knowledge on the best of my knowledge of my knowledge of my knowledge of my knowledge of my knowledge of my knowledge of my knowledge of my knowledge of my knowledg	id/or investi	gation, in my opinion,	death occurred at t	ne time, date and	place, and due	to the caus	se(s) and manner stated.		
Tot		29b. Signature and title of certifier 10.1000 MM MM		29c. License n	053	290	d. Date signed	(Month, Di	ay, Year) 2010		
141		30. Name and address of person who completed cause of death filem 23	LL	ew//yx	Ave	FT60	א פרבי	lead	20707		
Stat Registra	-	31. Date filed (Month, Day, Year) APR 2 7 2010 32. Registrar's Signature	1. p	are	· · · · · · · · · · · · · · · · · · ·		0		/		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of I	Maryland	•	artmen rtificate				R	eg. No.	2010	14849			
	Physicia		1. Decedent's Name (First, Middle, La Elizabeth Buck		mming						. Date of Deat April	2 ⁷ 29	20 Ĭ or	3. Time of Death 8:00 a M			
	/Medic Examin		4a. Facility Name (If not institution, giver 644 Taylors Is)				4b. City,	Town, or Tay	Location of	of Death Islan	and 4c. County of Death Dorchester						
	Funeral Director			Sex 7. 1 □ M 2 🖾 F	Age (In yrs. la	ast birthday) Yrs.	If Under Months		If Under Hours	Min.	B. Date of Birth (Month, Day, March 1	Year) 1,19	9. Birth Coul Rhod	place (State or Foreign ntry) Le Island			
	ryland how		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo		7 7	т.	_1 _ 1				10d. Inside City Limits			
1	h the Ma or 28a-f s	Funeral Director	MD Dorche				10f. Zip			sland	1		en of What Cou	1 □Yes 2 ☑ No			
3	ms 23a c	neral [644 Taylors Isl	12. Was Decede	ent Ever in U.S	S. 13. 1	Was Dece	dent of H	216		ify Yes or No-		USA 4. Race - Ameri				
036	urs after o al", or itel	þ	1 ☐ Never Married 2 ☐ Married 3 🙀 Widowed 4 ☐ Divorced	Armed Force 1 □Yes 2 If Yes, Give Year or Date	∑ No	Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☑ No Specify:							Black, White, Specify: Wh	etc. nite			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modeal Eventher is set to notified at once.	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4	or 5+)	(Give kind of work done during most of working life. DO NOT use retired)							d of Business/Ir				
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e, Ma	and 2 s fealth ar im 27 is her trau		Joan Kirkpatric			P. C). Box	1,	Taylo		sland,	MD	21669				
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		1	30. Name and appress of person who	- 00	of death (Item	n 23a) (Type,	Print)	-11	Ave	93 Suit	l j	Can	a bai di	EMP 21613			
	Sta Regist		31./Date filed (Month, Day, Year)		o strár's Signa	iture A.	fronk	1	111	, , ,				VI VI VI VI VI VI VI VI VI VI VI VI VI V			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month April 2010 9:10P M Richard L. Ferrenberg Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garner Ave. Waldorf Charles 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Birthpi-Country) PA 1 X M 2 □ F Hours Director 210-24-9077 February Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Charles Waldorf 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 518 Garner Ave. 20602 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married Completed by 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar If Yes, Give White 3
Widowed 4 Divorced Specify Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

FBI Communications Specialist 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Govt. 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William G. Ferrenberg Elsie Pharr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Ferrenberg/Wife 518 Garner Ave. Waldorf MD 20602 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Memorial Gar: 4/30/2010 4 ☐ Donation 5 ☐ Other (Specify) Waldorf, Maryland M00945 pf Funeral Service Licensee ²²AREHART ECHOL'S FUNERAL HOME, P.A. au Mary's Ave. La Plata.MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ an disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Pregnant at time of death Yes 2 No the 9 Unknown 9 Unknown by signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an has prior to completion of cause of death? page performed? Yes 2 No this certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2X No Hospital: Other: ျပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) inlury 5 Pending thin 24 hours after death.

the Funeral Director: After mpleted filled in by the fun 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Registrar

Medical

29a, Certifier

(Check

29b, Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Krishan Mathur, M.D. P.O. Box 1703, La Plata,MD

Year, 8

Ci

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Contifying Number Pranticipant To the basis of examination and/or investigation, in my opinion, death occurred at the line, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

April 26, 2010

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 22, 8:14 A Jonnie Figer Frisby Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charles LaPlata Civista Medical Center If Under 1 Year 9. Birthplace (State or Foreign Country) Texas Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth Funeral Days (Month, Day, Year) Nov 14, 1932 Min. 1 🗆 M 2 🗓 F 467 38 5668 77 Director Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🄀 No Maryland Forestville Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8106 Darcy Road Funeral 20747 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2XX No Specify: White 3XX Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 Health and Mental Hygiene. Item 27 is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Dept of Army Secretary or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Unavailable Unavailable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia M. Hemilton (Daughter) 10808 United Court, Waldorf, Maryland 20603 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of h Important: If ite any injury or ot 1XX Burial 2 Cremation 3 Removal from State Cheltenham, Maryland 5 Other (Specify) Maryland Veterans Cemetery May 5, 2010 4 Donation 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Clinton, Maryland Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nmediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician a s the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? To the Hospital or Attending Physician: "
within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jariwala, M.D. 11637 Terrace Drive #103, Waldorf, Maryland 20602 Manisha 31. Date filed (Mont) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2010 Year **Physician** 27, April 5:00P M Caleb Fetzer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 3480 Baptist Church Road Charles Nanjemoy If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 046-46-4563 52 July 20,1957 Director Usual Residence of Decedent 10d. Inside City Limits 3a or 28a-f show t be notified at 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No Director Charles MD Nanjemoy 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Number USA r than "natural", or Items 23a the Medical Examinar must t 3480 Baptist Church Road 20662 72 hours after death Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status
1 ☐ Never Married 2 ☐ Married Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Maryland 21215-0036 Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer Programmer Consulting Agency permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygic Important; If item 27 is marked other 1 any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Leila Vaill ပ Ernest Fetzer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 76 Coe Street, Winsted, CT 06098 Brooke Cheney Niece Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 🗡 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CT Valley Crematory May 10,2010 | Cromwell, CT 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Terrence L. Johnson Funeral Service 4433 White Plains Lane, Unit 1C, White Plains, MD M01284 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ischen /Medical Due to (or as a consequence of): Examiner Due to (or 3 /a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed burial-transit Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠Yes 2□ No 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No a Hospital or Attendi 24 hours after death. E Funeral Director: A etely filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

DHMH 17 Rev 1/2001

within 2

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

M. Tagovi MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. Tagour. MD

APR 30 2010

11655W: NESap

29c. License number

D0050883

ph

29d. Date signed (Month, Day, Year)

4/29/2010

Laplatu MD 20646

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The state of the s	Examir		4a. Facility Name (If not institution, giv Oakland Nursing					; Town, o aklaı	r Location of Death $\operatorname{nd} olimits$			4c. County of Dea Garrett	ith			
	Funeral		Social Security Number 6. S	Sex 7. Ag	ge (In yrs. las	st birthday)	If Unde Months	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of E	Birth	9. Bi	thplace (State or Forei		
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<u> a</u>	uld b Wents rrked rtic e	10	Morgan Ferrell						Saralta	Medi	.a	a				
ar	sho and l		19a. Informant's Name/Relationship (Type. Print)		19b. Mailing	Address	s (Street	and Number or Rur	al Route Nun	nber, Ci	ity or Town, State,	Zip Code)		
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1	/Medical Examiner		resulting in death)	Due to (or as	a consequer	nce of):										
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of	Phys this al dir	P.	1 Yes 2 No	1 L Inpatie	ent 2 EF				4 🗀 Nursing Ho			e 6 ☐ Other (Sp	ecify)			
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	To the within 2 To the comple	Me	29b. Signature and title of certifier	/			290	c. Licens	e number		29d.	Date signed (Mon	th, Day,	/ear)		

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kenneth Buczynski, MD 311 N. 4th Stre 311 N. 4th Street, Suite 1, Oakland, MD 31. Date filed (Month, Day, Year) Registrar's Signature

21550

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4854 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2010 Physician/ 10:00 P M April 24 Leonard FRANK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 X M 2 □ F Months Days Hours (Month, Day, Pennsylvania Director 117-14-6383 84 ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 72 hours after death with the Maryland Director Maryland Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? United States 10f. Zip Code 20906 3330 N. Leisure World Blvd., #724 Funeral items 12. Was Decedent Ever in U.S. Armed Forces?

1 1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. 0 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify Specify: "natural", 3 - Widowed 4 - Divorced Completed Year or Dates. WW II Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Mea one, Elementary/Seconday (0-12) College (1-4 or 5+) Retail Clothing Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Blanche Lerman Louis Frank 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 3330 N. Leisure World Blvd., #724, Silver Spring, MD 19a. Informant's Name/Relationship (Type, Print) Audrey Frank, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) King David Memorial Garden 04/28/10 Falls Church, VA 21. Signature of Fune A Service Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, 20012 23a. Part In Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician Dysphagia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Preumonia Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transit <u>Severe Malnutrition</u> Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Year 5 Other (specify) Month Yes 2 No the g 🗌 Unknown ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I à Biliary Stricture 1 Yes 2 No 3 Probably 4 Unknown Completed Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy certificate ha lirector, page 2 performed Yes 2 Arachnoid Tumor 1 🗌 Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 X No မြ 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending hin 24 hours after death. 1 X Natural 5 Pending work 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation within 24 hours after death

To the Funeral Director;

completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 5 29d. Date signed (Month, Day, Year)

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kshama Garg, M.D., 1500 Forest Glen Road, Silver Spring, MD

Registrar's Signature

uama

Month, Day, Year) APR 27

31. Date filed (M

D 60826

April 25, 2010

20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Donothy Fearing 9:30a 2010 18 <u>April</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Montabmer Social Security Number Under 24 Hrs. 8. Date of Birth (Month, Day, You May 12, 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Country) Ohio **Funeral** 1 □ M 2 💢 F Days 294-10-8567 90 Yrs. Director **1**919 Usual Residence of Decedent 10b. County 10a. State ms 23a or 28a-f sho must be notified at Director 10c. City, Town or Location 10d. Inside City Limits Silver Spring Montgomery M D 1XXYes 2 ☐ No 10f. Zip Code **20906** 10e. Street and Number 10g. Citizen of What Country? United States Funeral 3700 International Drive within 72 hours after death "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. δ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Completed 3 Widowed 4 Divorced Specify: Black the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) University Librarian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **Helen Yates** of Health and Mental H If item 27 is marked ot r other traumatic even မ Helen Robert Jackson of Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14324 Beaker Court, Burtonsville, Maryland 20866 Jeffrey Fearing 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of I-Important: If ite any injury or oth 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4/28/2010 Arlington, VA Arlington Nat'l Cem. 4 Donation 5 Other (Specify) McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licer 22. Name and Address of Facility The 40) 7400 Georgia Avenue, NW, Washington DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final PNCHMON, A Physician/ disease or condition resulting in death) Wecks Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Dusito (or se a consequence of, cause. Enter Underlying the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of). physician Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☑ No Pregnant at time of death Month Day Year After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ARTERY 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed DIAbeles 2 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 **Y** No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After the Completed filled in by the funeral 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 Accident 3 Suicide 4 Homicide 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

29b, Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SCHUENGOLD

3altimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Registrar DHMH 17 Rev 7/2009

State

29c. License number D18726

18111 Payer Philip Dr 7-10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** :40am SAMUEL PHILLIPS FRERE 010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Plate La 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. N. Date of Birth (Month, Day, Year) 8-6-1923 5. Social Security Number 7. Age (In vrs. last birthdav) **Funeral** Months Days Hours Min. 1 X M 2 □ F 218-18-4465 86 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State 28a-f show Director MD. CHARLES BEL ALTON 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 9780 BEL ALTON NEWTOWN ROAD 20611 U.S.A. 2**3**a T is marked other than "natural", or items 233 traumatic event, the "twoical Examinating must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ SpecifyWHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) CHARLES COUNTY Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT BUILDING INSPECTOR 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be 1 Health and Mental JOHN EDWARD FRERE MARY PHYLLIS MUDD ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DORIS FRERE-SPOUSE P.O.BOX 57 BEL ALTON, MD. 20611 permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tra once. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ST. IGNATIUS CEM. 5-11-2010 PORT TOBACCO, MD. 4 ☐ Donation 5 ☐ Other (Specify) M00479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 21. Signature of Emeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🚧 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 □ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No n 24 hours after death.

e Funeral Director: A pletely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 ho

To the Fune

completely f (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 au 2010 Name an laddress of person who completed cause of death (Item 23a) (Type, Print) 06 Waldorf MD 2060

DHMH 17 Rev 1/2001

State Registrar Date filed (Month, Day,

Year,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Year 4/23/2010 10:30 PM JAMES LEWIS GILCHRIST Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BETHESDA HEALTH & REHAB CENTER BETHESDA MONTGOMERY . Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Bennettaville, S(**Funeral** 1 🛛 M 2 🗆 F Days (Month, Day, Year 10/4/1947 Months Hours Min. Director 578-60-2935 62 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1X Yes 2 No Maryland | Prince George's Capitol Heights 10e. Street and Number 10g. Citizen of What Country? 23a 607 Cappy Ave. 20743 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14, Race - American Indian, Examiner þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates. the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Should be file and Mental H မ James C. Gilchrist Juanita Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Stanley Gilchrist / Brother Cappy Ave. Capitol Heights, Maryland 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4/28/2010 | Riverdale, Maryland Riverdale Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pope Funeral Homes, P.A. 23a. P. r. 1 Enter the discusse, or compiliations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5538 Marlboro Pike Forestville, Maryland 20747 Immediate Cause (Final Onset and Death Physician/ LUNC disease or condition resulting in death) CANCER Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate course. Fitted to religious Cause (Disease or iinjury Due to (or as a consequence of): sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 Yes 2 No 9 Unknown Month Day Year Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2₩No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 Ko Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending I hours after death. uneral Director: After and filled in by the fun 1 Tes 2 Accident 3 Suicide 4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical

State

Registrar

29a. Certifier (Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Ye

APR 2 9 2010

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32. Regis ar's Si

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao 9715 Medical Ctr. Drive

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Contribute Nursus Practionar To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20057124

suite 201 Rockville, Maryland 20850

29d. Date signed (Month, Day, Year)

4127110

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month GROOMS 9:15 PM ROSA LEOLA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner c. County of Death PRINCE GEORGE'S LANHAM DOCTOR'S HOSPITAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JULY 5 19 Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Min. 1 🗆 M 2 🛣 F Months Hours WASHINGTON, DC Director 87 577-28-6475 1922 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits must be notified PRINCE GEORGE'S LANHAM 1X Yes 2 ☐ No MD ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 20706 USA 7029 WOOD THRUSH DRIVE 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 1 ☐ Yes 2 ☑ No Specify: BLACK "natural" 3 - Widowed 4 X Divorced Year or Dates the Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meany injury or other traumatic event, the Meany Elementary/Seconday (0-12) College (1-4 or 5+) GOVERNMENT SPECIALIST 12TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ETHEL RAYFORD LAFAYETTE RUSSELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number. City of Town, State, Zip Code) 7029 WOOD THRUSH DRIVE LANHAM, MARYLAND 20706 SHERRI D. KITTRELL/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State RIVERDALE CREMATORY 4/29/2010 RIVERDALE, MARYLAND Donation 5 Other (Specify) Signatu 22. Name and Address of Facility ral Se J. B. JENKINS FUNERAL HOME Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Aspiration Pheumonia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Lines Underlying Cause (Disease or linjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director. After this certificate has been signed by the attending physician and the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) Day 1 Yes 2 g Unknown been signed by the s should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed 1 Yes 2. No Yes 2 1 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗹 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined

Division of Vital Records, P.O. Box 68760 To the Hospital within 24 hours a To the Funeral C

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

(Check

only one

31. Date filed (Month, Day,

29b. Signature and title of certifier

12150 Armapolis Re, Glenn Dale MD 20769 JAMH'LI MD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

20058213

29d. Date signed (Month, Day, Year)

4/27/10

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 1 | 1 | State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certific	ate of I	Death			R	eg. No.			
Physic Medical Exam		Decedent's Name (First, Middle,L	•	CAMPI					Date of Dea Month	ith Day	Yea	-	3. Time of Death
viedicai Exam	iner	MARK 4a. Facility Name (if not institution,	ERICK	GAMBI		. City, Town, o	or Location o	/	April 23, 2	2010	. County o		0058 hrs
		Prince George's Hospita	-			Cheverly	or Location C	or Death			nnce G		
Funeral		Social Security Number 6.	Sex 7. Age (I	n yrs. last bir	thday)	If Under 1 Ye		_					hplace (State or Foreign
Director		577-80-0395	X _M ₂ _F 46		Yrs.	Months Da	ys Hours	Min.	NOV. 8	3 19	63		untry) LYLAND
gue		Usual Residence of Decedent 10a. State 10b. County	J1č	c. City, Town	or Location								10d. Inside City Limits
*			GEORGE'S	CLINTO									1 X Yes 2 No
faryland 28a-f show Lat once.	Director	10e. Street and Number	GEORGE 5	CLINIC	10f. Zip Code					0g. Citi	zen of Wh		
0036 within 72 hours after death with the Maryland jene. her than "natural", or items 23a or 28a-f she Medical Examiner must be notified at once		8100 HAYFIELD C	OURT			20735				U	SA		
h with ems 23 t be ng	Funeral	11. Marital Status 1 Never Married 2 X Marri	12. Was Decedent Even			Decedent of H				-	14. Race White		can Indian, Black,
er deat , or its	Fur		1 X Yes 2	ARMY No				, i dei to i de	ari, oto.)				CV
urs afte tural" amine	d by	15. Decedent's Education (Specify	or Dates:	eted) 16a.		es 2 X N Usual Occup		kind of work	done	16b. H	Specify: (ind of Bus		
5-0036 led within 72 hours tygiene. other than "natur the Medical Exami	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)			t of working lif							,
003(within iene. er tha	ошо	12TH			POLIC	Œ					OVERI	MEN	IT
21215-00; uld be filed with: Mental Hygiene marked other ti	Be Co	17. Father's Name (First, Middle, La	st)					-	rst, Middle, M		Surname)		
2121 2121 Juld be fi Mental J marked	To B	PAUL BEAMAN 19a. Informant's Name/Relationship	(Type, Print)	198	o. Mailing A	ddress (Stre	ALFR eet and Num		GAMBLE I Route Num		ty or Town	, State,	Zip Code)
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. In 27 is marked other than numatic event, the Medica		GINA L. GAMBLE/	WIFE			IAYFIEI							20735
		20a. Method of Disposition 1 X Burial 2 Cremation	Removal from State	cremat	ory or other	n (Name of co	,		ate				Fown, State
Baltimore, permit. Pages I ar Department of Hei Important: If ite		4 Donation 5 Other Speci	ify:	HARMO		METERY		4/30					IARYLAND
Baltimo permit. Page Department Important: injury or otl		21. Signature of Fundral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL 7474 LANDOVER ROAD LANDOVER, MARYLAND											
Physician		23a. Part I. Enter the disease, or cor	nplications that caused the	death. Do no									Approximate Interval
Examiner		failure. List only one cause on Immediate Cause (Final disease	_{a.} Pulmonary Throm l	ooembolis	m							8	Between Onset and Death
/ Lxammer		or condition resulting in death)	Due to (or as a conseque	ence of):									
	ē	if any, leading to immediate	b Due to (or as a conseque	ence of):						_			
	Examiner	(Disease of injury that trittated	Due to (or as a conseque	ance of):								4	
executed an and al - transit		events resulting in death) Last	d.	since ory.									
40 177 177	Medical	UNPENDED	AMENDED										
760, ficate be g physicia the buria	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of								. Date of d		
Box 687 death certific the attending of for use as the	Physician/	past 12 months?	1 Live birth 4 Pregnant at time	2 e of death 5	Fetal	death 3 (Specify)	Ectopic	pregnancy			Month	Da	ay Year
BO ne deat the at	hys	1 Yes 2 No 9 Unknow	9OHKHOWH										
ires that the signed by I be detache	à	Part II. Other significant conditions cervical spine fractures,		t not resulting	in the unde	erlying cause	given in Par	t I.	23e. Did tot		_	_	ne cause of death?
ds, l	ted	cervical spirie fractures,	maxilary fracture						24a. Was a				opsy findings available
of Vital Records, ng Physician: The law requir wher this certificate has been s meral director, page 2 should	ompleted							-	autops perform	sy med?	pri de	or to co ath?	mpletion of cause of
Vital Reco ysician: The law his certificate has director, page 2 s	O	25. Was case referred to medical				26 Place	e of Death (Check only	1 Yes 2	2 No	1 [✓ Yes	2 No
Vita nysicia this cer	To Be		Hospital: 1 Inpatient	2 🗸 ER/Ou	tpatient 3		Other ₄			Resider	nce 6	Other:	
of Of Jing Phy. After the funeral		27. Manner of Death	28a. Date of Injury (Month, Day Year) Apr 18, 2010	28b. T 0331	ime of Injur		iry at Work?	Driv	l. Describe h				
ivisior or Attend after death. Director:	catic	2 Accident 5 Pending Investiga	ation	-			Yes 2 🗸 I	NO					
Was deceeded pregnant in the past 12 months? I								ate)					
Hospi 24 hou Funer tely fil	3 Suicide 6 Could not be determined (Specify) Major Road / Highway 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Route 301 Southbound at Malboro Pike 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 28f. Location (Street and Number or Rural For Town, State) Route 301 Southbound at Malboro Pike 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 28f. Location (Street and Number or Rural For Town, State) Route 301 Southbound at Malboro Pike 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examin	er:On the basis of examina and manner stated.										
4.										h, Day, Year)			
10		aun	11	7	·	O.C.	M.Ę.			April	23, 201	0	
81		 Name and address of person who Zabiullah Ali, M.D. Ass 	o completed cause of death sistant Medical Exam	, ,	1 Penn S	Street, Balt	timore, M	D 21201					
		31. Date filed (Month, Day, Year)	32. Registrar's S		west	,				_			
Regist		ADD 2.8 2010	Museus !	A AGA	exer								

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ GOODMAN FRANKLIN APRIL 4:40 Α Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FUTURECARE PINEVIEW NURSING HOME CLINTON PRINCE GEORGE'S Social Security Number If Under 1 Year If Under 24 Hrs. Date of bill. (Month, Day, Year 26 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min 1941 SOUTH CAROLINA Director 68 249-68-2018 SEPT Usual Residence of Decedent show 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD PRINCE GEORGE'S UPPER MARLBORO 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12804 RHINE ROAD 20772 USA 72 hours after death 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Yes. Give BLACK "natural", 3 X Widowed 4 □ Divorced Year or Dates hould be filed within 72 hours and Mental Hygiene. s marked other than "natura umatic event, the Medical E. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 6TH MACHINE OPERATOR PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ FRANKLIN GOODMAN SR. WILHAMENA BROWN should I and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) je 1 and 2 s t of Health a If item 27 i FRANCINE GOODMAN-SCOTT/DGT. 12804 RHINE ROAD UPPER MARLBORO, MARYLAND 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 ō 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or HOLLY HILL CHURCH CEME. 5/1/10 4 Donation 5 Other (Specify) ALVIN, SOUTH CAROLINA 21. Signature of Fun ral Service Licensee J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ACUTE CEREBROVASCULAR ACCIDENT Medical Due to (or as a consequence of) Examiner MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence oi). HYPERTENSION death certificate be executed burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical P.O. Box 68760 as 1 IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? ģ Month Day Pregnant at time of death Other (specify) 2 No the 9 🗌 Unknown 9 Unknown à signed b I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an page 2 autopsy performed? Hospital or Attending Physician: The 24 hours after death. certificate Yes 2X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 X Nursing Home 5 A Residence 6 Other (Specify) 2 🗓 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident Director; A Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours af

To the Funeral Di

completed filled in

State

DHMH 17 Rev 7/2009

Registrar

Medical

29a. Certifier

(Check only one) 29b. Signature and title of certific

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAXMI N. BERWA M.D

APR 2 8 2010

31. Date filed (Month, Day, Year)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

7700 OLD BRANCH AVENUE CLINTON, MARYLAND

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Morse Phactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D24535

29d. Date signed (Month, Day, Year)

2010

APRIL 26.

20735

	3 (Please Type or Print in Blac			
			1 - State Registrar	Department of Health and M Certificate of Death	lental Hygier Reg.	2010 11.061
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month 04-22-2	Day Year 3. Time of Death
20-11 July	Medic Examin	al	Susan F. Ghee 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		010 b: 55 P ^M 4c. County of Death
- Marie	Examin	er	Southern Maryland Hospital	Clinton		Prince George's
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birt.	hday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month Day, Yea) 6 - 1 3 - 1 9	9. Birthplace (State or Foreign Country) V A
	ld low	ڀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Location		10d. Inside City Limits
	arylan a-fsh fried	Director	,	emple Hills		1 X Yes 2 □ No
	or 28 e noti		10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	with s 23a ust b	Funeral	3420 Rickey Avenue, Apt. 138	20748		USA
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Merital Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ρ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
5-0	"natu	plet	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of workir	16b	o. Kind of Business Industry
121	within 72 giene. ner than t, the Me	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	life. DO NOT use retired)		deral Government
2	filed wit al Hygie d other event, th	Be C	12th Ho	ousekeeper	(First, Middle, Maid	
au	ild be file Mental narked c atic eve	10	James Olan Davis		C. Hange	·
ary	2 should th and M 27 is mar traumat		19a. Informant's Name/Relationship (Type, Print) 19b	. Mailing Address (Street and Number or Rural	Route Number, City	or Town, State, Zip Code)
	and 2 s Health s em 27 i			864 Wicker Ln., La	aPlata,	MD 20646
Baltimore,	permit. Page 1 al Department of H Important: If itel any injury or oth once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemeter	ry, crematory or other place)		.Location - City or Town, State uitland, Maryland
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee Mary Hedgman M0/374	22. Name and Address of Facility Cedar Hill FH,411	11 PA Av	20746 e.,Suitland, MD
	Physician/		23a. Part 1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	ot enter the mode of dying, such as cardiac or	r respiratory arrest,	Approximate Interval Between Onset and Death
and o	Medical Examiner		resulting in death) Due to (or as a consequence of	BOWEL OBST	71367	1011 7 10 CC+C
		ıer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of		100	on Ewcers
	ited d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	7		
	executec an and rial-transi		that initiated events resulting in death) Last C. Due to (or as a consequence of	of):		
90	te be nysicia he bui	dical	d			
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
Э.	the de by the ached	hys	9 Unknown			
ls, P.O.	uires that n signed t uld be det	Completed by P	Partyl. Other significant conditions contributing to death but not resulting.	n the underlying cause given in Part V	2	to use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Division of Vital Records,	as bee 2 sho	plet			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Rec	sician: The law certificate has I lirector, page 2 s	Com			performed	? death?
tal	cian: ertific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Check	only one)	
έVi	Physi this o	: To	1 Ves 2 No 1 Inpatient 2 ER/Ou 27. Manner of Death 28a. Date of injury 28b. T			6 ☐ Other (Specify)
o u	iding th. After funer	Certificate:		nijury work? M 1 Yes 2 No	8d. Describe how in	jury occurred
isio	Atter	rtifi	3 Suicide 6 Could not be 28e. Place of Injury - At home, far			and Number or Rural Route Number,
DΕ	tal or rs afte al Dire ed in l		building, etc. (Specify)		City or Town, Sta	ate)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, control one) 3 Certifying Nurse Practioner: To the best of my knowledge, control one) 3 Certifying Nurse Practioner: To the best of my knowledge, control one of the best of my knowledge, control one	r investigation, in my opinion, death occurred at t	the time, date and pla	ace, and due to the cause(s) and manner stated.
	P M M M M M M M M M M M M M M M M M M M		29b. Signature and title of certifier	29c. License number 0 - 1854.	5 AP	Date signed (Month, Day, Year) NIL 22, ZiO/O
			30. Name and didress of person who completed cause of death (Item 23a) (I	ype, Print) D LINE CENTER	- WACO	ONF, Md. 25602
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Kil		
DHM	MH 17 Rev 7/20	_	APR 2 8 2010 Church A. After			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 24. 2010 1:59 am Eli Guss Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Nursina Home Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland Month, Day, y March 06 1 🛛 M 2 🗆 F Months Days Min Director 579-07-1892 96 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1121 University Blvd., W., #1019 20902 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 should be filed within 72 hours afte and Mental Hygiene. is marked other than "natural", 1 ☐ Yes 2 🗓 No Specify: If Yes Give Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Owner/Operator 11 permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Guss Golda Risa Klein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie Lowenthal - Daughter 1121 University Blvd., W., #1019, Silver Spring, MD Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) King David Mem Grdns. 04/27/2010 | Falls Church. VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. AneMarie Warner 1232 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hypertensive Heart Disease disease or condition Medical resulting in death) Examiner Congestive Heart Failure Sequentially list conditions, Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence oi). Sick Sinus Syndrome sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical certificate be Chronic Obstructive Pulmonary Disease IF FEMALE: fyes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 X Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2 X No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 🗶 No ပ 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number,

Box Records, of Vital **Division**

To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JUNNA Weiner D0047330 April 26, 2010

💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

50 W. Edmonston Drive, Suite 207, Rockville, MD 20852 Thomas V. Joseph, MD

State Registrar

Medical

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 20. Robert Michael Glucksman 2010 8:00 a 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 D F Months Days Hours Min. New York Dec. 13, Year) Yrs. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🏝 No Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 20817 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. If Yes, Give Year or Dates. 1 ☐ Yes XX No Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Engineer Aerospace 18. Mother's Name (First, Middle, Maiden Surname)

Medical 4a. Facility Name (if not Institution, give street and number) **Examiner** National Lutheran Home Social Security Number **Funeral** 053-18-8379 Director Usual Residence of Decedent or 28a-f shov notified at show 10a. State within 72 hours after death with the Maryland Director Maryland 10e. Street and Number ò ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 7718 Cindy Lane 11. Marital Status þ 1 Never Married 2XX Married Baltimore, Maryland 21215-0036 Completed 3 Widowed 4 Divorced (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) Be Page 1 and 2 should be filed went of Health and Mental Hygant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) ည David Glucksman Henrietta Ginsburg traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzanne H. Glucksman/Wife 7718 Cindy Lane, Bethesda, MD 20817 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of h Important: If ite 20c. Location - City or Town, State 1 \square Burial 2 \blacksquare Cremation 3 \square Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory Alexandria, VA Signature of Funeral Service Licensee eva 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. , such as cardiac or respiratory arrest, Immediate Cause (Final Physician. disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or linjury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death

IF FEMALE:

Physician/

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical

2 410

Dav. Year

26

2010

1 🗌 Yes

29a. Certifier

31. Date filed (Month,

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death

Pregnant at time of death Unknown

3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____

23d. Date of delivery Day

gnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

autopsy

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Year

24a. Was an Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Į			26. Place of Death	Theck only one)	
I	Hospital: 1 Inpatient	2 ER/Outpatient	3 DOA Other: 4 Nursin	ng Home 5 Residence	6 Other (Specify)
	28a. Date of injury	28b. Time of	28c. Injury at	28d. Describe how in	

27. Manner of Death (Month, Day, Year) 1 Natural 5 Pending ☐ Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

injury 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu and title of certifier

29d. Date signed (Month, Day, Year) 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Charles Karesh, MD 9701 Veirs Drive, Rockville, MD 20850

State Registrar

the i

signed by the

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certificate

this funeral

s after death.

I Director: After to in by the funera

thin 24 hours after the Funeral Direct of the funeral Direct of the filled in by

To the I within 2 To the I comple

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Completed

Be

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Certificate:

Medical

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1:30 P Physician/ A₩9mt1 20 Pay2010 Year Goldstein Medical 4a. Facility Name (if not institution, give street and number)
11215 Seven Locks Road
Summerville Assisted Living Examiner 4b. City, Town, or Location of Death 4c. County of Death Potomac Montgomery If Under 1 Year Months Days Social Security Number 9. Birthplace (State or Foreign Funeral 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 1 □ M 2 🛛 F Days (Month, Day, Yea April 10 New York Hours Min. 213-46-7856 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits Directo MD Montgomery Potomac 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States Funeral 20854 11215 Seven Locks Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black White etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 X Widowed 4 □ Divorced If Yes, Give Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 hand Mental Hygiene.
7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Joseph Siegel Fannie Freedman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a 8808 Wandering Trail Drive Potomac MD 20852 Joel Goldstein - son permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 4 Donation 5 Other (Specify) National Crematory 04/23/2010 Falls Church, VA 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chanels Inc
1170 Rockville Pike Rockville DM 20852 21. Signature of Funeral Service Licensee. M0116323a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Myocardial Infarction
Due to (or as a consequence of): Medical Examiner Arterioschlerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an has autopsy performed? certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 😾 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 21, 2010 D20297 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

APR 26 2010

Box 68760

P.O.

Division of Vital

James H. Brodsky MD 4701 Willard Avenue SUite #224 Chevy Chase MD 20815

32. Registrar's Signature

10-01566 Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Maranda Lynn Bergdoll 1- For State Certificate of Death Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle, Last) 3 Time of Death Month Day February 21, 2010 Year 1249 hrs Medical Examiner MARANDA LYNN BERCDOLL GLENN MARANDA LYNN GLENN 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Winchester Road LaVale Allegany 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Min. Foreign Director 220-06-0668 Country) 1 M 2 X F 25 Yrs 05/16/1984 MARYLAND Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits ì Yes 2 No MD ALLEGANY CUMBERLAND Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 523 HENDERSON AVENUE 21502 U.S.A. Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 Yes If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed WHITE 4 X Divorced Specify: ≥ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than atic event, the Medical Baltimore, MD 21215-0036 9 (NONE) (NONE) 17, Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname)

20b. Place of Disposition (Name of cemetery,

HILLCREST MEML. PARK

crematory or other place)

Physician /Medical taminer

attending physician or use as the burial

s certificate has l rector, page 2 sh

After the

Certifica

Medical

State

Registra

3

one)

Suicide

Homicide

29b. Signature and title of certifie

Russell Alexander MD.

31. Date filed (Month, Day, Year)

Department

portant: If item 27 ury or other traums

Be

RICHARD LEE BERGDOLL

19a. Informant's Name/Relationship (Type, Print)

20a. Method of Disposition

4 Donation 5 Other Specify

SUSAN HINKLE / MOTHER

1 X Burial 2 Cremation 3 Removal from State

6 K Could not be

determined

30. Name and address of person who completed cause of death (Item 23a)

(Specify)

and manner stated.

other

Assistant Medical Examiner

MANA.

32. Registrar's Signature

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: A completely filled in by the fun

	Haraf Funeral Service Licens		RCH FUNERAL REENE STREE	HOME, P.A.	21502
	failure. List only one cause on each		dying, such as cardiac o	r respiratory arrest, shock, or heart	Approximate Inter Between Onset a Death
	PO	lypothermia			Deali
		to (or as a consequence of):			
.	Sequentially list conditions. b	invironmental cold exposi	ıre		
ē		to (or as a consequence of):			
Ē	cause. Enter Underlying Cause (Disease or injury that initiated				
Examiner	events resulting in death) Last Due	to (or as a consequence of):			
	d				
Physician/Medical	X UNPENDED	MENDED #1,PI_line a-b. PII, 2	27,28a-f,pei	r ME G903 5/25/10 T	Τ
ž		3c. If yes, outcome of pregnancy		23d. Date of delivery	
au	23b. Was decedent pregnant in the past 12 months?	Live birth 2 Fetal death	3 Ectopic pregna	ancy Month D	ay Year
<u>:</u>	1 Yes 2 No 9 ✓ Unknown	Pregnant at time of death 5 Other (Speci	fy)		
Š	T Pes 2 No 9 VINKHOWN	Unknown			
	Part II. Other significant conditions co	ntributing to death but not resulting in the underlying	cause given in Part I.	23e. Did tobacco use contribute to t	he cause of death?
ģ	Morphine into	cication		1 Yes 2 No 3 Prob	ably 4 🗹 Unknow
ē				24a. Was an 24b. Were aut	opsy findings availa
ompleted				autopsy prior to d	ompletion of cause
Ĕ				performed? death? 1 ✓ Yes 2 No 1 ✓ Ye	s 2 No
ပ	25. Was case referred to medical		6.Place of Death (Check		, 2 110
å		ital:			
0	1 Yes 2 No	1 Inpatient 2 ER/Outpatient 3 DE	A Outer4 Nursin	ng Home 5 Residence 6 🗸 Other	Scene
Ξ.	27. Manner of Death	28a. Date of Injury 28b. Time of Injury 26 (Month, Day, Year)	Bc. Injury at Work?	28d. Describe how injury occurred	
ation:	1 Natural 5 Pending	Fd 2/21/10 Fd 1230 hrs	1 Yes 2 X No	unk	
Ġ	2 Accident Investigation				

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City

linchester Rd LaVale, MD

or Town, State)

20c. Location - City or Town, State

No 3 Probably 4 V Unknown 24b. Were autopsy findings available prior to completion of cause of

CUMBERLAND, MD

21502 Approximate Interval

Between Onset and

28e. Place of Injury - At home, farm, street, factory, office building, etc.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number O.C.M.E.

111 Penn Street, Baltimore, MD 21201

February 22, 2010

SUSAN ANN MAGRUDER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

02/25/2010

819-B AVONDALE AVENUE, LAVALE, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14866 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 10:45 AM 2010 Bengt Carl Herder April 26, Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 701 Fallsgrove Drive #204 Rockville Montgomery 5. Social Security Number 6. Sex 1 🕶 M 2 🗆 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. April 8 Sweden Director 90 388–18–7868 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No Maryland Montgomery Rockville 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 701 Fallsgrove Drive #204 20850 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian rmed Forces?

XYes 2 No Black, White, etc. 1 Never Married 2 🔀 Married þ If Yes, Give Year or Dates.1941–46 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Language Elementary/Seconday (0-12) College (1-4 or 5+) Intelligence Agent/ Specialist should be filed with and Mental Hygier is marked other t Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit, Page 1 and 2 should be Department of Health and Ment, Important; If item 27 is marked any injury or act. Carl Daniel Herder Maria Alida Bexell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Herder/ wife 701 Fallsgrove Drive #204 Rockville, Maryland 20850 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Journey Crematory 4/27/2010 Woodbine, Maryland 21. Signature of Funeral Service Licenses 22 Name and Address of Eacility Going Home Cremation Service P.O. Box 784 stinoe M00957 Beverly L. Heckrotte, P.A. Clarksville, 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Renal Failure 18 days disease or condition Medical resulting in death) Due to (or as a consequence of Examiner <u>Hypotension</u> 2 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami and I-transit Due to (or as a consequence of) resulting in death) Last burial physician the burial Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Athersclerotic Cardiovascular Disease 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypernatremia autopsy page perform 1 ☐ Yes 2 ☐ No Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🔀 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending work? 1 Yes 2 No 1 X Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year, D31840 April 26, 2010

Registrar

State

Maryland 21215-0036

68760

Box

Records,

Vital

Division of

barks

9715 Medical Center Dr. Suite 214 Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Wayne L. Meyer, M.D

			1 - State Registrar Ce	artment of Health and Me	Reg. No.	0 1486
	Physici /Medic		1. Decedent's Name <i>(First, Middle, Last)</i> Donald Ellsworth Hyde		Date of Death Month Day April 27, 2010	3. Time of Death 9:40 P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of [Death
المس			Moran Manor Health Care Center	Westernport	Allegar	ny
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Days Hours Min. 8.	(Month, Day, Year)	Birthplace (State or Foreign Country)
	Director		220-20-9473		March 27 1935	Maryland
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Maryl f sho	ō	WV Mineral Fort	Ashby		1 □ Yes 💥 No
	the 1 28a-	rec	10e. Street and Number	10f. Zip Code	10g, Citizen of Wha	t Country?
	3a or	Funeral Director	HC 86, Box 411	26719	United S	tates
	ns 2	Jer	11. Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric	fy Yes or No- 14. Race - /	American Indian,
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "Modical Expression that the natified at	þ	1 Never Married 2 Married Armed Forces? 1957 1 X Yes 2 No 1957 1 Yes, Give 1959 1 Yes ar or Dates:	If Yes, specify Cuban, Mexican, Puerto Rio 1 ☐ Yes 2 ☑ No Specify:	Specify:	White, etc. White
2-0	72 ho	Completed		edent's Usual Occupation e kind of work done during most of working	16b. Kind of Busin	ess/Industry
7	thin 7	gu	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	Doulte	•
7	ed wi	ပ္ပ		ocessor	Poultr	<u>Y</u>
Maryland	be fill tal H ed oth	Be	17. Father's Name (First, Middle, Last) William T. Hyde	18. Mother's Name (F	First, Middle, Maiden Surname) Fazenbaker	
3	ould d Mer narke	은	-			
N N	d2sh than 7isr traur			ing Address <i>(Street and Number or Rural F</i> 1 Shady Lane, Apt.		
	1 and Heal Heal Heal Sern 2		-			
Baltimore,	permit, Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra once.		4 Donation 5 Other (Specify)	osition (Name of matory or other place) ill Cemetery 04/30/2		
Bal	permi Depar Impor any Ir			^{12. Name and Address of Facility} Boa 11 Church St, Weste	l Funeral Home rnport, Marylar	
			23a. Part1. Enter the disease, or complications that caused the death. Do not el shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or r	espiratory arrest,	Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition	piration pren	man make	Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):	, ,		
	Examiner	ارا	Sequentially list conditions. b.			
	ed sit	ine	Sequentially list conditions, if any heading to immediate cause. Enter Underlying Cause (Disease or injury			
	ecut and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c			
8760,	ate be executed hysician and the burial-transit		Due to (or as a consequence of).			
87	ifficate b g physions as the b	dical	d			
× 6	eath certific attending p for use as t	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			
Box	atten for us	ian	in the past 12 months? 1 Live birth 2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)	23d. Date o Month	fdelivery Day Year
P.O.	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Med	1 Yes 2 No 9 Unknown	□ Other (specify)		
	that i ed by detac	유	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribu	te to the cause of death?
Sp	uires sign Id be	d by	Astrance Dementi A	paylemen	1 Yes 2 No 3	Probably 4 Unknown
00	w requir s been s should	ete	(24a. Was an 24b. Wer	e autopsy findings available
of Vital Records,	he law e has ge 2 ;	Completed			autopsy prio performed? dea	r to completion of cause of
ā	sician: The certificate h rector, page		25. Was case referred to medical	20.81 (5. 1)	1-100	Yes 2□No
5	s cert irecto) Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death (C	o 5 ☐ Residence 6 ☐ Other (2
oţ	ding Phys h, After this funeral di	2:1	27. Manner of D ath 28a. Date of Injury 28b. Time		d. Describe how injury occurred	Specily)
Division	th, th, : Afte	Ę.	1 Natural 5 Pending (Month, Day, Year) Injury 2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
/isi	Atter r dea sctor	iji	3 ☐ Suicide 6 ☐ Could not be 28e, Place of Injury - At home, farm, s	reet, factory, office 28f	f. Location (Street and Number of	or Rural Route Number,
Ö	al or	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, State)	
	To the Hospital or Attending within 24 hours after death, To the Funeral Director: After completely filled in by the fune	Medical (29a. Certifler (Check only one) 1 Certifying Physician: To the best of my knowledge, dea and manner stated.			
	To th within To th comp	ME	29b. Signature and title of certifier	29c. License number	29d. Date signed (M	Month, Day, Year)
		2		D21244	4/28	12010
	4	X VA	30. Name and address of person who completed cause of death (Item 23a) (Type Dr. Jesus Tan, 4 Broadway, Frostbur	, Print)		
	Sta Registr		31. Date filed (Manth Ray Year) 2010 32 Registrar's Signature	ne		
DHI	MH 17 Rev 1/20	001				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of I	Maryland / D	-	ment of ficate of		and M	_	giene Reg. No.	2010	Į Lį	868
	Physicia	an	1. Decedent's Name (First, Middle, La	,						Date of Dea Month	ath Day	Year	3. Time of	
70	/Medic	al	Jeannette Beale				O: T			April	23	2010 County of Death	8:40	_₽™
	Examin	er	4a. Facility Name (<i>If not institution, gi</i> t Berlin Nursing F		er)	46	o. City, Town, Berli		or Death			rcester		
	Funeral				Age (In yrs. last birti		Under 1 Year	If Under		8. Date of Birt	th	9. Birth	place (State o	r Foreign
	Director		577-26-2029	1 □ M 2 🔀 F	87	Yrs. M	onths Days	Hours	Min.	1/1/19	23 <i>Year)</i>	Wash	ington	DC
	pu »		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location	on						10d. Inside Cit	ty Limits
	laryla shov	ō	,		,								1 □Yes	
	the N 28a-1	Director	MD Worcest 10e. Street and Number	.er	Ocean		10f. Zip Code				10g. Citi	izen of What Cou	intry?	
	3a or	Ö	10 Clipper Ct.				2181	1			U	SA		
	death	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.S.	13. Was	Decedent of	Hispanic Or	igin? (Spe	cify Yes or No Rican, etc.)	-	14. Race - Amer Black, White		
36	after or ite		1 Never Married 2 Married	Armed Force 1 □Yes 2 If Yes, Give			Yes 2 No			,,				
ő	hours tural"	yd be	3 ☑ Widowed 4 ☐ Divorced	Year or Date		Decedent	t'e Heual Occi	ination			16h Ki	nd of Business/li	white	
H-15-	in 72 "nat	Completed	15. Decedent's E (Specify only highest gr	ade completed)	10a.	(Give kind life. DO	t's Usual Occu d of work done NOT use retire	e during mos ed)	t of workin	ng .	100. 10	nd of business/i	industry	
212	d with giene r thau	mo	Elem <i>e</i> ntary/Secondary (0-12)	College (1-4	or 5+)	Homen	naker				0	wn Home		
act	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Las	1)				18. Mothe	er's Name	(First, Middle,	Maiden	Surname)		
Van Van	ould b Ment arked atic e	70	Richard A. Belf	ield					Rosa					
ibble, Jeannette Bose	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once.		19a. Informant's Name/Relationship									r Town, State, Z	ip Code)	
e, N	1 and Health	-	Deborah J. Blake 20a. Method of Disposition	e / daugh						Pines,		Z1811 ocation - City or 1	own, State	-
Jor Jor	nt of l		1 ☐ Burial 2 🛣 Cremation 3 [20b. Place of cemeter							nkford,		
쁄	artme artme ortant Injury		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		cape	_	open Cr					ral Hom		
Han	permi Depar Impor any Ir		>////////////	8M						erlin,			-	
	Physician		23a. Part J Emer the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition	pplications that cau one cause on eac	sed the death. Do n	not enter t	he mode of dy	ring, such as	-	r respiratory a	rrest,		Approximate Interval Bette Onset and I	ween
	/Medical Examiner		resulting in death)	Due to (or	as a consequence of	of):			0)20					
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence of	of):								
	ate be executed oblysician and the burial-transit	хаш	that initiated events resulting in death) Last	c	as a consequence of	of):								
8760,	sician burta	ical E		3.00										
687	ificate g phys			d						_				
O. Box	Attending Physician: The law requires that the death certificate be executed or death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burlal-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown		th 2 Fetal death nt at time of death		ctopic pregnar ther (specify)	ncy				23d. Date of del Month	,	Year
ds, P.	law requires that the deas been signed by the 2 should be detached	β	Part II. Other significant conditions	contributing to dea	th but not resulting in	the unde	rlying cause g	iven in Part	l.	23e. Did 1		us <i>e</i> contribute to		death? Unknown
Division of Vital Records,	he law rec te has bee age 2 shot	Completed									psy ormed?	prior to death?	topsy findings completion of c	available ause of
ita	an: 1 rtifica tor, p	Be C	25. Was case referred to medical					26. Plac	e of Death	1 □Yes f(Check only o	2i⊌ No one)) ILlies	20110	
>	nysic nis ce direc	O B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	oatient 2 ER/Ou	ıtpatient	3 □ DOA O	ther: 4 N	ursing Hor	me 5 🗌 Resi	idence	6 ☐ Other (Spe	cify)	
ion o	ath. r: After the funeral	ation:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation		Injury 28b. T Day, Year) Ir	Time of njury	28c. Inj	ury at ork? □Yes 2 □	2	28d. Describe				
Divis	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification: To	3 Suicide 6 Could not l	200. Place 0	Injury - At home, far , etc. <i>(Specify)</i>	rm, street,	, factory, office)	2	28f. Location (City or To	Street ar wn, State	nd Number or Ru e)	iral Route Num	iber,
	he Hospi in 24 hou he Funer pletely fili	Medical	29a. Certifier (Check only one) CertifyIng F	hysiclan: To the b miner: On the bas and manne	est of my knowledge is of examination an r stated.	e, death oo nd/or inves	ccurred at the stigation, in my	time, date a opinion, de	ath occurr	and due to the ed at the time	, date an	d place, and due	to the cause(s	;)
	To t To t	N	29b. Signature and the of certifier		MA			0.69	607	2		ate signed (Mont	h, Day, Year)	
			30. Name and address of person wh	completed cause	of death (Item 23a) ((Type, Pri	nt)	<u> </u>	~	, Ber	-	40)	10	
	£.7 3	te.	Nawiu 31. Date filed (Month, Day, Year)	32.00	gistrar's Signature	715	Healt	hway	DR.	, Ber	le	r, me) व्यक्ष	n
	Registr	-	APR 272	010	me . A.	Jan	Kal							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 1:25 24 2010 A^{M} April Madelyn A. Hasco /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Raphael House Rockville Montgomery 8. Date of Birth (Month, Day, YOct. 20, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** . 192<u>1</u> Months Days Hours 1 □ M 2 🗓 F Pennsylvania 88 173-18-7264 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits and Mental Hygiene. is marked other than "natural" or items 23a or 28a-f show raumatic event, the fred free Example and the modified at Rockville Director 1 ☐ Yes 2 ☐ No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 13716 Flint Rock Road 20853 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Long Distance Operator 12 AT&T17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be in ment of Health and Mental Michael Posick 2 Rose Stipcovic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra Joan Kennedy (Daughter) 13716 Flint Rock Road Rockville, Maryland 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 2010 Silver Spring, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home TEACH A. JUSEN 10 East Deer Park Drive Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Cancer Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Physician; The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and burial-tra Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): attending physician Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🗖 No Month Day Vear 5 Other (specify) the detached 9 I I Inknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 🗗 No 2 🗌 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) Certification: To 1∐ Yes 2∐XNo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After 1 28d. Describe how injury occurred 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending hours after death

filled in by 24 hours a within 2 To the I 2

ca

State

Registrar

29a. Certifier (Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Barry N. Rosenbaum M.D. 3720 Farragut Avenue Kensington, Maryland 20895 31. Date filed (Month, Day, Year) 82. Registrar's Signature APR 27 2010

and manner stated.

1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D09834

29c. License number

29d. Date signed (Month, Day, Year)

April 26, 2010

10-03296 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Kimberly Haley State of Maryland / Department of Health and Mental Hygiene 2010 1487 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day April 28, 2010 Medical Examiner Kimberley Frances Haley 1038 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYY) 9. Birthplace (State or Funeral July 1 1967 Foreign District Country) of Colum Months Davs Hours Min. Director 212-02-3956 42 1 M 2 X F Yrs Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 X No MD Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13122 Shadyside Lane 20874 ā United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes 4 Divorced If Yes, Give Year 3 Widowed 1 Yes 2 X No specify: White Specify: ò 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry ted during most of working life. DO NOT use retired)
Electronic Fingerprint
Specialist Elementary/Secondary (0-12) College (1-4 or 5+) Comple Financial Regulatory 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) John James Haley Be Julia Louise Sprinkle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Taylor / Sister 381 Hickory Nut Court, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, 1 X Burial 2 Cremation 3 Removal from State All Souls Cemetery May 3, 2010 Important: I Germantown, MD 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, 178166 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a Ethanol & diphenhydramine intoxication & drowning Immediate Cause (Final disease Examiner or condition resulting in death) Sequentially list conditions, One to for as a consequence of Examine If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical X UNPENDED AMENDED, PII, 27, 28a-f, per ME g903 5/13/10 TT attending physician or use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? for use Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown has been signed by the 2 should be detached f Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 V No 3 Probably 4 Unknown Cocaine use Completed director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? this certificate Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other DOA 2 1 V Yes No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work 28d Describe how injury occurred Subject used alcohol & drug & drowned Certification: 1 Natural 1 Yes 2 X No Pending hours after death Director: d in by the /28/2010 In bathtub Fd 10:05 am Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 X Suicide Could not be or Town, State) determined (Specify) residence the Funeral 5545 Burnside Dr. Rockville, MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 h Medical one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

7-PEN

31. Date filed (Month, State Registra

Victor Weedn MD JD Assistant Medical Examiner 05°2010

and manner stated

111 Penn Street, Baltimore, MD 21201

29c. License number

OCME

29d. Date signed (Month, Day, Year)

April 29, 2010

ORIGINAL

areas.

most

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 19a, State of Maryland Department of Health and Mental Hygiene State Registrar John Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:35 P M Apri John C. Heiser Medical 4a. Facility Name (if not institution, give street and number) Examiner County of Death VA Maryland

5. Social Security Number JUSER If Under 24 Hrs. Hours Min. If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F 04-13-192 Baltimore, Director 217-16-2757 Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Cecil Perry Point or 28a-f 1 Yes 2 No MISICION: 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 21902 VA Maryland Health Care System USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Completed by 1 Never Married 2 Married should be filed within 72 hours after Specify: White 1 ☐ Yes 2 X No Specify: Year or Dates 1942-45 "natural", 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Branch Chief Dept. of Defense Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward C. Heiser Amy Belle Frock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1980 Ridge Rd., Gettysburg, PA 17325 Sharon Mavron, Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Joy Cemetery permit. Page 1
Department of
Important: If it
any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State May 7, 2010 Gettysburg, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility JL Davis Funeral Service Licensee

23. Name and Address of Facility JL Davis Funeral Service Licensee

24. Name and Address of Facility JL Davis Funeral Service Licensee

25. Name and Address of Facility JL Davis Funeral Service Licensee

26. Name and Address of Facility JL Davis Funeral Service Licensee

27. Name and Address of Facility JL Davis Funeral Service Licensee

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29. Name and Address of Facility JL Davis Funeral Service Licensee

29. Name and Address of Facilit 22. Name and Address of Facility JL Davis Funeral Home 12525 Bradbury Ave., Smithsburg, MD 21783 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Nonknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an After this certificate has autops, performed? within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 **X**000 욘 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 22773 29d. Date signed (Month, Day, Year) MD 0726921 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marykind Health Pare Susten Perry Point MD 21900 egistrar's Signatur State Registrar

DHMH 17 Rev 7/2009

DIL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Jacqueline B. Heffner 12:16 p^M 23, 2010 April 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death 1529 Stone Road Westminster Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□ M 2 F Days 61 Mar 25, 220-52-3941 1949 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21158 1529 Stone Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Specify Specify: white 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Health Care Nurses Aide 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Feeser Allen Becker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1529 Stone Road, Westminster, MD 21158 Randy E. Heffner, son 20b. Place of Disposition (Name of School Place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/26/2010 Winfield, MD Carroll Crematory 21. Signature of Funeral Service License 22. Name and Address of Facility Myers-Durboraw Funeral Home سلمي morans 91 Willis Street, Westminster, MD 21157 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hronic Obstre 40 K disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ZNo 9 Unknown 9 Unknown Part II. Other significant conditions, contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 1 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 - Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide

Examiner or Attending Physician: The law requires that the death certificate be executed Box 68760. physician P.0. of Vital Records, peen has certificate this

for use as the burial-transi signed by the a page 2 s director, within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral To the Hospital o within 24 hours af To the Funeral Di

Physician

/Medical

Examiner

Funeral

Director

28a-f show

23a

or items

death with ō

permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Innerrany Injury or other traumatic event was once.

Physician

/Medical

Director

Funeral

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Completed

Be

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Examiner

Be Completed by Physician/Medical

Certification: To

Medical

4 ☐ Homicide

29b. Signature and title of certifier

29a. Certifier

traumatic event, the Medical Examiner must be notified at

WJL

Division

State Registrar DHMH 17 Rev 1/2001 elas

determined

MA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stoner

31. Date filed (Month, Day, Year) 32. Registrar's Signature

and manner stated.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Emma Jean Isaacs April 24 2010 7:18p ^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster Carroll Dove House If Under 1 Year | If Under 24 Hrs. 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🛛 F Yrs. 69 **Director** 217-36-7950 April 27,1940 Missouri Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a local Evan mer rust be notified a since. 1X Yes 2 □ No Director Carroll Maryland Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 Watersville Road 21771 United States Funeral . Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 K Divorced DOY EHOUS =

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:00 P M LENA MAE JOHNSON APRIL 27 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3350 CEDAR CHURCH ROAD HARFORD DARLINGTON | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | AUGUST 5, 1 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🕱 F 82 215-30-7834 1927 MARYLAND Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c, City, Town or Location 10b. County 23a or 28a-f show ust be notified at 1 ☐ Yes 2 No Director MARYLAND HARFORD DARLINGTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code an "natural", or items 23a or Medical Examiner must be 3350 CEDAR CHURCH ROAD 21034 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌠 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. Specify: BLACK þ 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien. Important: If item 27 is marked other the any injury or other traumatic event, the Jones. DOMESTIC ENGINEER FEDERAL GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RALPH SMITH CARRIE ELSIE PRICE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ROBERT R. SMITH / BROTHER 3321 CEDAR CHURCH ROAD, DARLINGTON, MD 21034 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST. JAMES UAME CEM. 05/03/10 DARLINGTON, MARYLAND 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME, P.A.
552 LEWIS STREET, HAVRE DE GRACE, MD 21078 21. Signature of Funeral Service Licenses Coleman Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** oronary Artery /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed and burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of page 2 s perform death? 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death

1 Natural

2 Accident 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funeral 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

within 2 To the

2

Year) 31. Date filed (Month, Day, APR 3 0 2016

29b. Signature and title of certifier

30 Name and address of person who commetted cause of death (Item 23a) (Type, Print)

Benjamin Lee, MD 669 Revolution

nd manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Havrede Grace MD 21078

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Linda 201<u>0</u> Jean Johnson 22 0208 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, March 9 6. Sex 9. Birthplace (State or Foreign Country) Washington DC **Funeral** 1 □ M 2 🖾 F Months Days Hours Min 63 578-92-6169 Director <u>March</u> Usual Residence of Decedent 10a. State 10b. County with the Maryland ems 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director DC Washington tyt☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7415 9th St NW 20012 United States within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. ö δ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2x No Specify: Specify: Black "natural" Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. I other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Disable None Ith and Mental Hygie 27 is marked other r traumatic event, tl Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other traumation once. ည James M Johnson Marguerite Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vivian Romero/Sister 3736 N. Calle Entrade Tucson AZ 85749 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Lincoln Cemetery 4-29-2010 Suitland MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service L 22. Name and Address of Facility Washington DC 20020 al onz Pope Funeral Home 2617 Penn Ave SE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) ASPIRATION PNEUMONIA Medical Due to (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions, cause (Disease or linjury Due to for as a nonsectioned on -transit executed DIABETES TYPE II and that initiated events resulting in death) Last Due to (or as a consequence of) the burialattending physician for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death n signed by the a Id be detached f Yes 2X No 1 ☐ Yes 2X 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MENTAL RETARDATION 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate | 2 🗌 No Yes 2XX No 1 TYes Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital: 2 No Other: 1 X Yes ၉ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA eral Director: After this filled in by the funeral di 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined the Hospital 24 hours a Medical 29a. Certifier 1💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and tille of certifier 29c. License number 29d. Date signed (Month, Day, Year,

State

SHAHID SHAMIM, MD 7600 CARROLL AVE 31. Date filed (Month, Day, Year)

TAKOMA PARK MARYLAND 20912 32: Registrar's §

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAMIN, MID

Registrar

D-5928

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month April 22, 2010 Year Cecelia Larue Jones 2:33 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 15005 Eardley Court Silver Spring Montgomery Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** ^{Year)}1922 Country Pennsylvani Feb. 18 1 M 2 K F Months 211-14-0088 Yrs. Director 88 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-1 1 🗌 Yes 2 🏝 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be Funeral ms 23a 15005 Eardley Court 20906 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: **Black** 3 K Widowed 4 Divorced "natural" Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 12 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ဂ DeLos Fulwylie Gertrude Peyton other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol A. Jones/Daughter 3409 Hallaton Court, Silver Spring, MD 20906 April 24 2010 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Page 1 ō <u>=</u> 24, ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State ò Department of Important: If any injury or once. Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Sign were of Funeral Service License 22 Name and Address of Facility Funeral Home Inc. Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, of co shock, or heart failure. List only mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Years Immediate Cause (Final h sician/ disease or condition resulting in death) Coronary Artery Disease Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 🏝 No Month Dav Year Pregnant at time of death certificate has been signed by the irector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Emphysema Completed 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? Yes 2X No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🙀 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 🛣 Naturai 5 Pending 1 Yes 2 No Accident Investigation Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) April 23, 2010 D23958

Registrar DHMH 17 Rev 7/2009

State

68760

Box

P.O.

Records,

Division of Vital

Registrar's Signature

3305 N. Leisure World Blvd., Silver Spring, MD 20906

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bert I. Feldman, MD

Day, Year)

26 2010

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	-	for State Amended #19a	State of Mary	FCHD 5/5	artment of H 110 tificate of D	ieaith and iv De <i>ath</i>	rentai mygiei Reg.	ne No. 2 A A	11.977
Di	,	Decedent's Name (First, Middle, La					2. Date of Death Month	Day Year	3. Time of Death
Physicia Medic	al	Emily H.						2, 2010	5:00 P M
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Director		579-03-3899	1□M2□X 98	Yrs.	Months Days	Hours Min.	Nov. 2.	1911 Wa	shington, DC
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or 28		10e. Street and Number	SIICK		10f. Zip Code	Frederic		Citizen of What Co	untry?
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r item		11. Marital Status	12. Was Decedent Ever in Armed Forces?	13. U.S.	Nas Decedent of His f Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
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lental rked tic ev	2	John Hodkins	son				ttie Ingr		
and M is ma		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a		_	or Town, State, Zip	Code)
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or of		20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State	b. Place of Dispo cemetery, crer	isition (Name of natory or other place	9)		. Location - City or	
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and die o		Muntinger	Staulber	1	621 Oposs	umtown P	ike, Fred	erick, MD	
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sian ar urial-tı	ш	resulting in death) Last	Due to (or as a con	sequence of):					
physic the b	edic		d						
nding use as	~ I	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		7			23d. Date of deli	ivery
e atte	sicia	in the past 12 months? 1 Yes 2 \(\sum_{1}^{\text{V}}\) No	1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at time g ☐ Unknown		Other (specify)			Month	Day Year
d by the	Phy	g Unknown Part II. Other significant conditions		t resulting in the u	inderlying cause give	en in Part I	23a Did tobacc	co use contribute to	the cause of death?
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been	Completed			-			24a. Was an	24b. Were aut	opsy findings available
te has	JIIIO						autopsy performed 1 \(\sum \) Yes 2 \(\sum \)	l? death?	completion of cause of 2 No
ortifica ctor, p		25. Was case referred to medical examiner?			26. Pla	ice of Death (Check		NO TE ICO	7
this ce al dire	ျေ	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of injury	ER/Outpatier		4 LX Nursing Ho		6 Other (Speci	fy)
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within 24 hours after To the Funeral Directory completed filled in Example 1 or 1 or 1 or 1 or 1 or 1 or 1 or 1 o	Medical	(Check 2 Medical Exan			death occurred at the 29c. License	time, date and place	e, and due to the cau		stated.
24 hours Funeral	Medica	(Check 2 Medical Examonly one) 3 Certifying Nu	niner: On the basis of examin		death occurred at the 29c. License	time, date and place	e, and due to the cau	se(s) and manner as	stated. , Day, Year)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month April **Physician** Day 28 Year Atlee Calvin Kepler 1:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Fahrney-Keedy Home and Village Washington county Boonsboro 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min 1 XM 2 □ F 215-20-7567 **Director** 3,1921 Marvland Usual Residence of Decedent with the Maryland 10a. State 10h County 10c. City, Town or Location d other than "natural", or Items 23a or 28a-f show event, the "Madical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 XNo Maryland | Washington county | Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1542 Kensington Dr. 21742 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other traumatic control. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) College President 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl McKinley Kepler ဂ Amy Gladhill Kepler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annabelle Kepler-wife 1542 Kensington Dr. Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 4-30-2010 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pouglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a onsequence of): Examiner Cardio mys Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Atria burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 1 ☐Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autonsy performed' 1 □Yes 2 ☑No 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 → No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: £ 2 Accident investigation 1 ☐ Yes 2 No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 396 00 60 8/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUNSAED 3H-15+1 ARID

State

31. Date filed (Month, Day, Year) APR 2 9 2011

32. Registrar's Signature

1126 Opal Ct., Hagerstown, MD

Registrar

10-02948 Charles R. Krause Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar				Certific	ate of	Death			Reg	g. No.		
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Wedical Examin	ier	CHARL 4a. Facility Name (if not ins		R.	KRA1	USE		b. City, Town, o	r I ocation		April 15, 20		ty of Death	
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Funeral		5. Social Security Number	6. Se	×	7. Age (Ir	n yrs. last bir	thday)	If Under 1 Ye			8. Date of Birth	(MM/DD/YY	Foreig	thplace (State or
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Ì	21. Signature of Funeral Se		see			22. Na CH	me and Addres	s of Facility FUNER	AL HO	ME & CE	REMATO	RIUM,	P.A.
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		30. Name and address of pe Donna M. Vincenti		ompleted caus Assistant N			111	Penn Street	, Baltimo	ore, MD 2	21201			
Sta Registi	ate rar	31. Date filed (Month, Day,)	2010	22. Re	egistrar's S	ignature	ark	D						
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OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ РМ JoAnn S. Kemp 2010 APRTI 9:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY 17328 FLETCHALL ROAD POOLESVILLE If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 3 71 0272877939 488-44-8228 MO Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director POOLESVILLE MONTGOMERY 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20837 17328 FLETCHALL USA ROAD 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces? If Yes, specify Culan, Mexican, Puerto Rican, etc. Black, White, etc. 1 Mever Married 2 Married Yes 2 No Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DOMESTIC HOUSEWIFE 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ MILDRED CROSS JOHN SHARP 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17404 SOPER STREET, POOLESVILLE, MD 20837 DIANE STIDHAM / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State st. MARY S CEMET. 04/26/2010 BARNESVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Pun al Sinvio Licenses 22. Name and Address of Facility .0 HILTON FUNERAL HOME BARNESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition Onset and Death √nysician/ METASTATIC ADENOCARCINOMA OF LUNG mos Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Il or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ BRAIN METASTASIS 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 🗀 Yes 2 **2** No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State, e Hospital o 24 hours af e Funeral D Medical 1 Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D31362 Marlene ·Hayman 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARLENE HAYMAN, MD501 N. FREDERICK RD., GAITHERSBURG, 31. Date filed (Month, Day Year) 32. Registrar's Signature State 20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 ear Physician/ Month Day 27 3:50p M Iris M. Quiles Lopez de Ferrara Apr. Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner 29 Stirrup Drive Ceci1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🛛 F Hours Min. Oct. 5, Country) 086-24-5267 Director 87 Usual Residence of Decedent show at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified 1 🗌 Yes 2 😾 No MD Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 29 Stirrup Drive 21921 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 filed within 72 hours after 1 XYes 2 No Specify: Puerto Rican Specify: White "natural" Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Should be filed within 7. h and Mental Hygiene. 7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Felix Quiles Francisca Lopez t. Page 1 and 2 should by thent of Health and Mertant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vivian Ferrara-Machado/daughter 29 Stirrup Drive Elkton, MD 21921 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 4/29/2010 permit. Page 1 Department of Important: If it 1 🗆 Burial 2 XCremation 3 🗀 Removal from State cemetery, crematory or other place) Foard Funeral Home, 4 Donation 5 Other (Specify) P.A. R.T. Rising Sun, MD rure of Funeral Service Licenses 22. Name and Address of Facility R Foard and 259 E. Main St. Gee Elkton, MD 21921 23a. Part 1 Enter the disease, or complication shock, or heart failure. List only one call that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate on each line Interval Between Onset and Death Immediate Cause (Final Arley clisas Priysician/ disease or condition resulting in death) unbnown Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and -tran Due to (or as a consequence of): attending physician of for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death the a should be detached 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No After this certificate has 2 🗆 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 M Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 1 only one) 29b. Signature and title 29c. License number 2 10023322 Sicholey S. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

SACHIDEN MD

31. Date filed (Month, Day, Year)

126 A,

32. Registrar's Signature

E High ST , Electon MD 2/92/.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mantal Hygiene Amend Items 25,27,28a-f per me. g903,05/21/2010 Mantal Hygiene Certificate of Death Reg. No. 1 - State Registra Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** PM April 22 2010 6:30 Arlene G. Livengood /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Garrett Goodwill Mennonite Home Grantsville If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F June 26, 1937 Maryland Director 163-32-2304 72 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County 1 □Yes 2 X No Examiner must be notified Director Grantsville MD Garrett 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21536 USA 4418 Chestnut Ridge Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 Never Married 2 Married 1 ∐Yes 2 🔀 If Yes, Give Year or Dates: 2 👿 No Baltimore, Maryland 21215-0036 1 □Yes 2 XNo Specify. Specify: à 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Textiles Seamstress 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hulda Mason Lester Bittinger ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21536 of Health of Item 27 is Rosanne Livengood/Daughter-in-law 4418 Chestnut Ridge Rd., Grantsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Department of Important: If It 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Injury or Country Side Crematory April 26, 2010 Davidsville, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licensee Low 2 eumai P.O. Box 275, Grantsville, MD 21536 Approximate Interval Between Onset and Death 23a. Part 1. Ent care disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Hrs. **Physician** disease or condition resulting in death) /Medical Due to (or as a x nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending p for use as 33 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown s een signed by should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an this certificate has all director, page 2 sh autopsy performed? 1 Yes 2 No raction 25. Was case referred to medical 26. Place of Death (Check only one) Be niner? examiner 1 Yes Hospital: Other: AND Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral dif 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury a 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 □Yes 2 XNo Subject fell 04/12/2010 Unknown M 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 891 Dorsey Hotel 4 Homicide Nursing Home

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. within 24 hours after death

To the Funeral Director:
completely filled in by the

Certification: To

Medical

29a. Certifier

(Check only

Grantsville,MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in examination death.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

the em

21502 Muhammad Naeem, 625 Kent Ave., Suite 204, Cumberland, MD

State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 4/25/2010 Year ROBERT L. LIPSCOMB 3:45 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death PRINCE GEORGE"S 7901 ASHDALE ROAD CAPITOL HEIGHTS . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Henrietta, NC 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Days 1 XM 2 □ F 9/21/1935 **Director** Yrs. 240-46-4978 74 Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 ☐ No Capitol Heights Maryland Prince George's 10e, Street and Number 10g, Citizen of What Country? Funeral 7901 Ashdale Road 20743 United States Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by x Yes 2 ☐ No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 x No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Printer Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F ၉ Samuel Lipscomb Sarah Sims and i 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 2 other 1 Constance Lipscomb / Wife Ashdale RD. Capt. Heights, Maryland 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date <u>o</u> = . 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State permit. Page Department Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 4/30/2010 Maryland Veterans Cheltenham, Maryland Signature of Funeral Service License 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville Maryland 20747 tavece 01 01000 23a. Par Etter the disease. If complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of the line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a o Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Certificate: To Be Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🔲 No Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 1 Inpatient 2 TR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 2 No Accident Suicide Investigation 6 C Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title of cert

State Registrar of gerson who completed cause of death (frem 23a) (Type

OTTO

Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Day 2010 Year Charles H. M. Littleford 26, 2:35 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Takoma Park Montgomery Washington Adventist Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 X M 2 - F Months Days Hours Min (Month, Day, November 214-52-4228 Director 60 Cheverly, MD Usual Residence of Decedent or 28a-f show 10b. County 10a. State 10c. City. Town or Location ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Prince George's Hyattsville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3313 Lancer Drive 20782 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black. White, etc þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: White Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Senate Office Building Painter Decorator 12 Be th and Mental H 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Wallace C. Littleford Alice Gilmore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Der artment of Health ar Important: If item 27 is any injury or other trau 3313 Lancer Drive, Hyattsville, MD 20782 Lillie M. Littleford / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 4/27/2010 Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 RAZ RUSANS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Vear Pregnant at time of death signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: မ 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Funeral Director; After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending Natural Accident Suicide 5 \square Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death mumod at the time idate and plane and due to t causals) and his mores stata STUL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3415 Hamlton ST H

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Division of Vital

MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 6:50 pm Evelyn Smith Lindner 25, April 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Eden Homes of Greywood Bethesda 8. Date of Birth (Month, Day, Year) June 21, 1913 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country)

10f. Zip Code

Potomac

7. Age (In yrs. last birthday)

10c. City, Town or Location

96

1 □ M 2 🗓 F

Montgomery

4885

Pennsylvania

10g. Citizen of What Country?

10d. Inside City Limits

1 ☐ Yes 2 🔯 No

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment for refilled at

Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

For State Registrar

5. Social Security Number

10a. State

Maryland

10e. Street and Number

207-10-5104

10b. County

Usual Residence of Decedent

Physic /Med Examí

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

Division of Vital Records, P.O. Box 68760,

at to	al D	11705 Bunnel	ll Court North		20854		и.:	S.A.
er me	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of I If Yes, specify Cub	lispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
any injury or other traumatic event, the Medical Expruirer must be once.	þ	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ∐Yes 2 MANo If Yes, Give Year or Dates:	1 □Yes 2 No	Specify:		Specify:	White
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ent, II	Be Cc	17. Father's Name (First, Middle, Last,		201000		(First, Middle, Maider		
tic ev	To B	ļ t	Henry Smith			Esther Li	fschitz	
anma		19a. Informant's Name/Relationship (Type. Print) 19b	o. Mailing Address (Street	and Number or Rura	I Route Number, City	or Town, State, Zij	o Code)
er tra		Margery Ginsberg		1705 Bunnell				
o of		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 X	20b. Place of cemete Removal from State	of Disposition (Name of ery, crematory or other pla	ce) D		ocation - City or To	•
int.		4 □ Donation 5 □ Other (Specif	(y) Both E	l Memorial	Park 04/27	/2010 whi	tenace, re	ennsykvania
any		21. Signature of Funeral Service Licer	1800 MO # 1010					Home, Inc. 1g, MD 20904
п		23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do one cause on each line.	not enter the mode of dyi	ng, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
ian		Immedia use (Final disease or condition resulting in death)	a. Aspiration Pn	eumonia				Onset and Death
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Tor u	ician	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ☑No	1 ☐ Live birth 2 ☐ Fetal death	n 3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		Month	Day Year
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oe dei	by P	Part II. Other significant conditions of	contributing to death but not resulting i	n the underlying cause given	ven in Part I.			the cause of death?
pino		Hypertension				1 ☐ Yes 2	No 3 Pro	bably 4 Unknown
e Z sh	Completed	Non Insulin Depe	<u>endent Diabetes M</u>	ellitus		24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
, page	Con					performed? 1 □ Yes 2 🗓 No	death? 1 ☐ Yes	2 🗆 No
rector	Be	25. Was case referred to medical examiner?	Hospital:	Ott	26. Place of Death			Assisted
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	ation	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury Wor M 1 □	rk?]Yes 2 □No			
in by th	Certifica	3 Suicide 6 Could not b 4 Homicide determined		arm, street, factory, office	-	28f. Location (Street a City or Town, Stat	nd Number or Rur e)	ral Route Number,
completely filled in by the	Medical Co		hysician: To the best of my knowledg miner: On the basis of examination a and manner stated.					
ompie	Mec	29b. Signature and title of certifier	and marmer stated.	29c. Licen:	se number	29d. Da	ate signed (Month	, Day, Year)
0) /dm/	Y >		D35579		April 26	. 2010
		30. Name and address of person who	completed cause of death (Item 23a)	(Type, Print)			1 2 2 2	
		Susan Miller, MD,	, 8218 Wisconsin	Aue., #305,	Bethesda,	Maryland	20814	

Registrar

27 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle,Last) Physician/ Date of Death 3. Time of Death Day Month 0614 hrs Medical Examiner Daniel Andre Lamoureux May 2, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 18050 Chalet Drive, Apartment 102 Germantown Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** Country) Months Days Hours Director 213-81-5423 50 03/11/1960 Canada 1 X M 2 F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 X No Montgomery Germantown hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 18050 Chalet Drive, #102 20874 Canada Funeral 11 Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Yes White 3 Widowed f Yes, Give Year 1 Yes 2 X No specify: Divorced ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 h and Mental Hygiene. 27 is marked other than 21215-0036 12 Web Designer Computers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surriame) Rene Plante Pierrette Lamoureux 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S 18050 Chalet Drive, #102, Germantown, Md. 20874 Marie Lamoureux / Wife ent of Health and: If item 27 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) Department Important: 5/4/10 Metropolitan Crem. Alexandria, Va. Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home 0 Box 5038 Lavtonsville 20882 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Complications of chronic alcohol abuse Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed g physician and the burial - trans Physician/Medical AMENDED 23a. X UNPENDED pII, 27, per ME g903 5/24/10 TT Box 68760, IF FEMALE: 23b. Was decedent pregnant in the 23d. Date of delivery 1 Live birth use as t 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? á 1 Yes 2 No 3 Probably 4 V Unknown Salicylate toxicity Completed of Vital Records, peen 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed' death? certificate ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) æ examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other: Nursing Home 5 Residence 6 Other: Scene DOA this 1 ✓ Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Division 1 Yes 2 No Director: d in by the f 5 Pending 2 Accident Investigation To the Hospital or At within 24 hours after d To the Funeral Direct 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 4 Homicide 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 2, 2010 omulle 30. Name and address a person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** HELENA THERESA LOWERY 04 29 2010 1450 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Western MD Regional Medical Center Allegany Cumberland Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2 🔀 F 214-07-1835 Director 93 07/10/1916 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if it Medical Examinations. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 □ No Director MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 714 Frederick Street Funeral 21502 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Completed by 1 ☐ Yes 2**X** No Specify: Specify: 3X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Allegany County Elementary/Secondary (0-12) College (1-4or 5+) Board of Education Cafeteria Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas A. Burkey Nellie Schilling ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Kight / Nephew 12106 Old Cash Valley RD, NW, LaVale, MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Meml. Park 05/04/2010 Cumberland, MD 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Hafer Funeral Service, P.A. 1302 National Highway, LaVale, MD phy 23a. Part I Enter the diseast or comshow, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ist only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) MYCCARDIAL INFARCTION **Physician** /Medical ue to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 ☐ No 2 1 No 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a/(Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Robustiano J. Barrera,

31. Date filed (Month, Day, Year)

32. Registrar Signat re

Jr., M.D. - 200 Glenn Street, Cumberland, MD

21502

Box 68760, P.0. Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 4/20/2010 Physician/ Ruth Ann Martin 1930 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth **Funeral** Hours Min 1 M 2 XX 871571917 219-01-4853 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 Yes XX No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1918 Fairfax Rd. 21401 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2XXXNo Specify: White If Yes, Give Year or Dates 2/ is marked other than "natural", traumatic event, the Medical Exai Specify: 3 ₩idowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Administrative Assistant Cemetery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, 12 should be file alth and Mental | 27 is marked o ပ James B. Armiger Ruth McNamara permit. Page 1 and 2 st Department of Health an. Important: If item 27 is m any injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Knight Daughter 152 Wild Heron Villas Rd. Savannah, GA 31419 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a, Method of Disposition 20c. Location - City or Town, State 1 🖾 urial 2 🗆 Cremation 3 🗆 Removal from State 4/24/2010 4 Donation 5 Other (Specify) Hillcrest Cemetery Annapolis, MD 21. Signature of Funeral Service Ligence 22. Name and Address of Facility Hardesty, Funeral Home, P.A. TX 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Myocardial disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Ulmonary edema Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examir and I-transit Ulcer with perforation that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-t Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🐼 No Dav Pregnant at time of death signed by the a d be detached f 1 Yes 2 2 Unknown a 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown has been si ge 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 Yes 2 No certificate Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 1 Tyes 2 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending injury work? after death. 2 No 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d Date signed (Month, Day, Year) nelle 69566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IVE lisse Milhel Ziol Medical Parkway, Annapolis 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

3 Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mc Graw 22 Day 2010 Physician/ April Lucille 3:15p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Olney Montgomery General Hospital If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign **Funeral** 6. Sex Dec 9, 1923 1 □ M 2X F Months Davs Hours Pennsylvania **Director** 200-16-0875 86 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at filed within 72 hours after death with the Maryland al Hygiene. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Montgomery Village Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20325 Trolley Crossing Court 20886 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Nidowed 4 Divorced Year or Dates White marked other than "natu matic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) . Page 1 and 2 should be filed tment of Health and Mental Hy tant; If item 27 is marked oth 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important; If item 27 is marked any linJury or other traumatic ev once. ၉ Fritz John Klepadlo Rosemary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886 20325 Trolley Crossing Ct Montgomery Village, MD Lynn McGraw/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1
Burial 2
Cremation 3
Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 4/24/2010 Woodbine, Maryland 21. Sign tur of Funeral Service License Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Homa M00957 Marita 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Myocardia Immediate Cause (Final Infantion Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list solutions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 4 tonknown page 2 should Hnemin 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? emeny After this certificate 2 No 2 1100 1 🗌 Yes Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 ☐ No မ 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident
Suicide s after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or if vestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ATU D063999 22/2010 Mounes 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ata Motamedi, M.D. 17904 Georgia Avenue, Suite 304 Olney, Maryland 20832

State

Registrar

31. Date filed (Month, Day, Year) APR 2 7

32. Registrar's Signature

Geneva

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2010 Year А. м 8:28 **Physician** McDowell April 24, Isaiah Alan /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Hyattsville 404 Willow Hill Pl. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. July 21, 10 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** M☐M 2☐F 45 1964 D.C. 578-02-8277 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State 10b. County r than "natural", or itams 23a or 28a-f show the Modical Examiner must be notified at 1X Yes 2 □ No Hyattsville Prince George's Direct 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 20785 U.S. 404 Willow Hill Place Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, African-American filed within 72 hours after Hygiene. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Contractor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic svant 900g. Arlita Johnson Vadon McDowell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 404 Willow Hill Pl., Hyattsville, MD 20785 Monica L. McDowell-Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Neme of cemetery, crematory or other place) Date 20a. Method of Disposition Fort Lincoln Cemetery May 3, 2010 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Brentwood, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bonnette & Assoc. Funeral Home 21. Signature of Funeral Service Licensee 2504 28th St., N.E., WDC 20018 23. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest stock, or heart failure. List only one cause on each line. Immediate Cause (Final Myocardial infarction & Arrhythmia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Diabetes, Hypertension use as the burial-tran and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician the death certificate be Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 X Yes 2 No 3 Probably 4 Unknown To Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 No page 2 1 Yes certificate Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1 Tes 2 No 3 DOA 28b. Time of Injury 28d. Describe how injury occurred filled in by the funeral 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 27. Manner of Death Medical Certification: or Attending 5 Pending 1 Yes 2 No after death. investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital within 24 hours a To the Funerel (1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 28 D52706 O. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ashenati Waktola, MD 5804 Baltimore Ave., Hyattsville, MD 20781 30. Name and address of person who comp 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 04 Month 2010 Ρ. 23 Moy Chung Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery <u>Shady Grove Adventist Hospital</u> <u>Rockville</u> . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 □ F Months Hours Min. 07/05/1936 Director Canton China 577-72-0665 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 X Yes 2 □ No Gaithersburg MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20882 9700 Huntmaster Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married 1 Yes Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural". 3 Widowed 4 Divorced Year or Dates Chinese permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Chef Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Tsao Qui Kee Mov Sue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gaithersburg, MD 20882 <u>Sui King Moy / Spouse</u> 9700 Huntmaster Road Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Lincoln Cemetery 05/01/2010 Brentwood, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home, Montionnem Cheatton 20722 Brentwood, MD 3401 Bladensburg Road 23a. Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ disease or condition resulting in death) Acute Respiratory Failure Minutes Medical Due to (or as a consequence of) Examiner Acute Myocardial Infarction Minutes Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examil s been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 X No page 2 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 2 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🛛 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation after death filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

CR3

State Registrar 31. Date filed (Month, Day, Year)

APR 2 9 2010

enter pr.

Rockuille MD 20850

. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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		For State Registrar	State of	Marylar		rtment of latificate of				giene Neg. No.	0	14892
		Decedent's Name (First, Middle, L.	ast)						2. Date of Dea	ıth	Vaar	3. Time of Death
Physicia		Raymond David N	McNeill					I I	April 2	1, Day 2010	Yeer	12:44pM
/Medic Examin		4a. Facility Name (If not institution, g.		nber)		4b. City, Town,	or Location of	of Death		4c. County	of Death	
	Ĭ	Manor Care Heal	th Care	Center		Po	tomac			Mont	gome	ry
Funeral Director		5. Social Security Number 6. 245–54–9836	Sex 1⊠M 2□F	7. Age (In yrs. 74	last birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birth (Month, Day Feb. 2	7, Year) 3, 1936	Cou	place (State or Foreign ntry) th Carolina
		Usual Residence of Decedent							100. 20	, 1550	1101	. cii Gardizii
f show	or	10a. State 10b. County D. C.			ty, Town or Lo shingto							10d. Inside City Limits M☐ Yes 2 ☐ No
28a-	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of W	Vhat Cou	ntry?
Sa of	۵	3322 14th Stree	et. N. W.	#426		2001	0			U.S.	Α.	
The 2	Funeral	11. Marital Status	12. Was Dece	dent Ever in U	J.S. 13. V	Was Decedent of	Hispanic Ori	igin? (Spec	ify Yes or No-	14. Race	e - Ameri	can Indian,
r Itar	Ē	1 Never Married 2 Married		2 No		f Yes, specify Cul			lican, etc.)		k, White,	
urs a	Ď	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Da	e ates:		I□Yes 250 No	Specify:			Specify	: B1a	ick
z no natur	ted	15. Decedent's (Specify only highest g				lent's Usual Occu		t of workin	0	16b. Kind of Bu	siness/lr	ndustry
We i	nple.	Elementary/Secondary (0-12)	College (1-	-4or 5+)	life. L	OO NOT use retire	ed)		3	C1	11	C = -
/gien	Completed	9th			Gas	Station					ne11	Gas
permit. Pages 1 and 2 should be lifed within 7.2 hours after death with the Marylain bepartment of Health and Mental Hygiene. Impertment of Health and Mental Hygiene. Importment: If term 27 is marked other than "natural", or Itame 23a or 28a-f show any injury or other traumatic event, the Medical Examine must be notified at once.	To Be	17. Father's Name (First, Middle, Las Hector McNeill	st)					er's Name y Tor		Maiden Surnam	e)	
and A ama ama		19a. Informant's Name/Relationship	(Type, Print)	Son	19b. Mailin	g Address (Stree	t and Numbe	er or Rural	Route Numbe	r, City or Town,	State, Zi	p Code)
alth alth 27 i		Raymond David M	cNeil, J	r. Sui	1522	Ruston	Avenu	e Ca	pitol 1	H ei ghts	, Md	20748
of He item		20a. Method of Disposition	□ D		Place of Dispo	sition (Name of natory or other pla	ace)	Da	ate	20c. Location -	City or T	own, State
rage int: If		1 Burial 2 Cremation 3 4 □ Donation 5 □ Other (Spec		M	ount Z	ion Ceme	tery	04/30	0/2010	Baltim	ore,	Maryland
partin ports y inju		21. Signature of Funeral Service Lic	ensee			. Name and Addr			77	_		
8 9 1 8 8		(Karen Very	MI CE	020	34	47H14Eh	Stree	neral	Home W	inc. ashingto	on, l	D. C. 20010
		23a. Pant. Enter the disease, or co	mplications that ca	aused the dea								Approximate Interval Between
hysician		Immediate Cause (Final	/		on Pail							Onset and Death
/Medical	ļ	disease or condition resulting in death)	a	or as a consec	an Fail	Lure						months
Examiner					o Thriv	70					100	onths
	e	Sequentially list conditions, if any, leading to immediate		or as a consec		, <u> </u>						OIICIIS
ured d ansit	E I	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Deme	ntia								months
exec n an ial-tr	Examiner	resulting in death) Last		or as a consec	quence of):							
e be execute /sician and e burial-tran	dical		d Ente	ritis								weeks
g ph)	edi											
w requires that the beath certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		irth 2□Feta ant at time of a	al death 3	Ectopic pregnan Other (specify)	су			23d. Dat Mo	le of deliv	v ery Day Year
mar ned b	y P	Part II. Other significant conditions	contributing to de	ath but not re	sulting in the u	nderlying cause g	iven in Part I	1.	23e. Did to	obacco use conti	ribute to	the cause of death?
ures sign	d by	Dysphagia							1 🗆 Y	res 2€ No	3 🗆 Pro	bably 4 Unknown
ine law requires that the te has been signed by th tage 2 should be detache	Completed	Osteoporosis							24a. Was	an 24b. \	Were aut	oosy findings available
has has ge 2	m d								autoc	rmed?	death?	opsy findings available ompletion of cause of
ficate		OF Man ages referred to modical						(5)	1 Yes		I ☐ Yes	2 ☑ No
certi	Be c	25. Was case referred to medical examiner?	Hospital:] CB(0		thos		(Check only o		ar /Caaa	
ral di	- 10	1 ☐ Yes 2 ☑ No 27. Manner of Death			ER/Outpatien	I 3 DOA	4 XINI			tence 6 Oth		iry)
After fune	Certification:	1 ☑Natural 5 ☐ Pending		of Injury h, Day Year)	Injury	W	ork? ∃Yes 2.⊟			. ,		
deat deat ctor: / the	ica	3 Suicide 6 Could not	be 380 Place	of Injury - At h	nome, farm, str	eet, factory, office			8f. Location (S	Street and Numb	er or Ru	ral Route Number,
after Dire	erti	4 ☐ Homicide determine	buildir	ng, etc. (Speci	ify)				City or Tox	vn, State)		
purs ours ierel filled		29a, Certifier Certifying	Physician: To the	best of my kn	owledge death	occurred at the	time date an	nd place, a	nd due to the	cause(s) and ma	nner as	stated.
Fun Fun etely	edical	(Check only 2 Medical Ex	aminer: On the ba	asis of examin	ation and/or in	vestigation, in my	opinion, dea	ath occurre	d at the time,	date and place,	and due	to the cause(s)
to the Hoppitel of Attending Priysician: The law within 24 hours after death. To the Funerel Director: After this certificate has l completely filled in by the funeral director, page 2.s.	Me	29b. Signature and title of certifier	_			29c. Licer	nse number			29d. Date signe	d (Month	, Day, Year)
- S + Ö		* XO:	() 1 ·			DI	960	39		April	27,	2010
5		30. Name and address of person wh	o completed caus	e of death (Ite	m 23a) (Tyne	Print)	(0)					
20		Raman Tuli, M.D		108	lo Darn	stown Ro	ad St	uite	202 G	aithersb	ourg	, Md. 20878
Sta	10	31. Date filed (Month, Day, Year)		egistrar's Sign	ature							

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

parker APR 2 8 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert John Michela 22^{Day} 2010^{ear} AMONTA 1:00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Timonium Stella Maris Hospice Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 573 50 8397 1 □XM 2 □ F 71 Hours 0770671938 California Director Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director VA Loudoun Potomac Falls 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 47589 Griffith Place 20165 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces' 1 X Yes 2 If Yes, Give ve 1964<u>-</u> 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 Divorced Year or Dates. 15. Decedent's Education 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Colone1 US Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Katharine Lial Joseph A. Michela 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 47589 Griffith Place/Potomac Falls VA 20165 Catherine Michela (wife) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Nemoval from State Arlington VA Arlington Nat Cemetery 08/23/2010 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Advent Funeral Services 7211 Lee Highway Falls Church VA 22046 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) COLON CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical ROBERT MICHELA Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Yes 2 No ed by the a 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ within 24 hours after death.

Jo the Funeral Director: After this certificate has been sit completed filled in by the funeral director, page 2 should t 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗶 No |은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 4/22/2010 30. Name and address of person who complete red cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

JENNIFER HAUF

31. Date filed (Month, Day, Year)

27

DULANEY VALLEY RD.

TIMONIUM, MD 21093

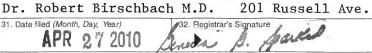
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar2MFND#19bperFH, 4/27/10, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 25, MARY LOUISA MAGRUDER 2010 9:40 LEWIS April A^{M} /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 415 Russell Ave. #809 Gaithersburg Montgomery 8. Date of Birth (Month, Day, Ye Feb. 13, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 1920 Maryland Days Months Hours 1 □ M 2 🗓 F 90 579-14-1552 Director Usual Residence of Decedent within 72 hours after death with the Marylanc 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examinar must be notified at 1 X Yes 2 ☐ No Director Maryland Montgomery Gaithersburg 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 415 Russell Ave. #809 20877 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: 2 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Edward Lewis Mary Hughs Pages 1 and 2 should ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other tratonce. 405 Russell Ave. Gaithersburg, MD 20877 Walter H. Magruder Sr. (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition April 26, 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State Metropolitan Crem. Alexandria, Va. 4 ☐ Donation 15 ☐ Other (Specify) 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a. Adult Failure to Thrive **Physician** Month disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Dementia (Alzheimers Disease) Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed burial-trar Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte I be detached for u in the past 12 months? Month Day Year 5 ☐ Other (specify) □Yes 2XNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Coronary Artery Disease, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown is certificate has been s director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No Osteoarthritis, Osteoporosis 24a, Was an autopsy performed? 1 □ Yes 2 🔀 No Hyperlipidemia, Hypertension 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) 27 2010 APR

V. Cakest Birschla

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



04115

April 25, 2010

Gaithersburg, MD 20877

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Frances Matilda Maki April 5:40 pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 11313 Norris Drive Wheaton Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 □ M 2 🗓 F Months Days Hours Min. **Director** 212-56-5308 59 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2 Y No Wheaton Maryland Montgomery 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 11313 Norris Drive 20902 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 X Divorced Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Ith and Mental Hygiene
27 is marked other that
raumatic event, the Senior Procurement Analyst U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Paul Edward Maki Jenny Sophia Raukko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 11313 Norris Drive, Wheaton, Maryland 20902 Bruce Wallace - Friend 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔲 Burial 2 🕱 Cremation 3 🗀 Removal from State Lincoln Crematory 04/26/2010 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death
6 months Ph_sician/ Small Cell Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): ysician and e burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🗶 No Year 4 ☐ Pregnant at time of death g ☐ Unknown 1 Yes 2 2 9 Unknown Division of Vital Records, P.O. Part II. **Other signific**an<mark>t conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🕱 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred s after dea. ral Director: After 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a 29d. Date signed (Month, Day, Year) April 23, 2010 D29675 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #4100, Bethesda, Maryland 20817 MD, 6420 Rockledge Drive. Ralph Boccia,

Registrar

State

31. Date filed (Month, Day, Year)

26

DHMH 17 Rev 7/2009

Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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hysici	ian			thran									2010	Year	3. Time of D 8:17
/Medic		4a. Facility Name (If not institut	Tri .		nhar)		4h City	Town or	Location of	of Death	APLII		4c. County of	f Death	0.17
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neral		5. Social Security Number	6. Sex		7. Age (In yrs	. last birthday)		r 1 Year	If Under:	24 Hrs.	8. Date of	Birth			place (State or
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Ì		Usual Residence of Decedent													
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	by F	3 Widowed 4 □ Divorc		If Yes, Giv	е		1 🗌 Yes	2 X No	Specify:				Specify:	Whit	۵
ä	ted	15. Deced	ent's Educ	cation		16a. Dece	dent's Usu	al Occupa	ition			16b.	Kind of Busi		
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other traumatic		19a. Informant's Name/Relatio	, , , , ,	· · · · · · · · · · · · · · · · · · ·							al Route Nur				Code)
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any injury or of		21. Signature of Funeral Service	ce License	96		F	ranci	Addres	s of Facilia	lins	Funer	_			, MD 20
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ician dical niner		23a. Part1. Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a a	Due to (ary Art	th. Do not ent	er the mod	de of dying							Approximate Interval Betwee Onset and De
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ P M SCOTT MOSER ${ t APRIL}$ 2010 3:45 CELIA Medical 4a. Facility Name (if not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY COLLINGSWOOD NURSING ROCKVILLE HOME If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Country) GA 1 - M 2 - F Months Davs Hours 0572571946 Director 258-70-0371 63 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Yes 2 No MONTGOMERY BOYDS MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14204 BRASS WHEEL ROAD 20841 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 ☐ Yes 2 ☑ No Specify: Specify: WHITE "natural", 3 ☑ Widowed 4 ☐ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Is once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOUSEKEEPING HEALTH CARE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 MAUDE JOSEY JAMES SCOTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11489 BRUNDIDGE TERR., GERMANTOWN, MD 20876 PAUL MOSER / SON 20b. Place of Disposition (Name of cemetery, crematory or other place)
MONOCACY CEMETERY 20a. Methød of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 04/26/2010 BEALLSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Licensee 22. Name and Address of Facility P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunal-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🕱 No Month Day Year page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 Yes 2 No 2 No Yes å 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending n 24 hours after death.

Ie Funeral Director: Aft
oleted filled in by the fur ☐ Accident☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00062435 Malecular Dr. Rockville, MD 20850 30. Name and address of person who completed cause of death (Item 23a) (Type Print) 0110 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19a per fb 2903 5-20-10 yt State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Donald Woodrow Moore II Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Birthplace (State or Foreign Country)
 PA 7. Age (In vrs. last birthday) If Under 1 8. Date of Birth **Funeral** (Month, Day 1**X** M 2 □ F Min Director 184-38-6818 62 Yrs. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he material once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director WV Mineral Keyser 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral HC 72, Box 204 26726 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ XNever Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2X No Specify Specify: white 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Film Scanner Data Processing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donald Woodrow Moore Lillie Rockenbaugh 19a. Informante Narry Belationship (Type, Print)
Anne Crowley sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 150 Eisenhower Dr., Chambersburg, PA 17201 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Potomac Memorial 5/10/2010 Keyser, 21. Signature of Funeral Service Licenses Name and Address of Facility Markwood Funeral Home,
P.O. Box 912, Keyser,

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Inc Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final OTTUCEN Physician PHAGEAL disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** JAC Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Day Year sate has been signed by the page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No s after death.

Director: After this certificate 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 No ၉ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1/X Natural 5 Pending 2 Accident 1 Tes 2 🗌 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in the opinion, usual to control at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

and title of certifier

Podrumar,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

"MD,

32. Registrar's gnatur

29b. Signature

Alida

904 Seton Dr., Cumberland,

2010

MD 21502

10-03433 Brenda Sue M c0		Please Type or Print in Black Indelible Ink. Ensure All Cormick State of Maryland / Department of Health and Menta 1-For State Registrar Certificate of Death	opies Are Legible. al Hygiene	10 1489			
Physici			Date of Death Month Day Year	3. Time of Death			
Medical Exami	ner	Brenda Bde Medorimiek	May 3, 2010	2108 hrs			
		4a. Facility Name (if not institution, give street and number) 310 Love Run Road 4b. City, Town, or Location of Colora	Death 4c. County of Cecil	Death			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2	` 1.				
Director		203-46-2533 1 M 2 X F 54 Yrs. Months Days Hours	Min. Sept. 18, 1955	Foreign Country) PA			
		Usual Residence of Decedent					
w any		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits			
land f sho	io	MD Cecil Rising Sun		1 Yes 2 No			
Mary 28a-	Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What	t Country?			
h the 3a or	ā	9 Octoraro Park Lane 21911	USA				
th wit	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin 1 Never Married 2 Married Armed Forces? 14. Was Decedent of Hispanic Origin 15. Was Decedent of Hispanic Origin 16. If Yes, specify Cuban, Mexican, P		American Indian, Black, etc.			
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136 hin 72 than edical	Completed	School Bus Driver	Public S	Sahoola			
d wit		17. Father's Name (First, Middle, Last) 18. Mother's	Name (First, Middle, Maiden Surname)	CHOOLS			
215 be file rtal H ked o	Be (Sallee				
21 ould I	힏		er or Rural Route Number, City or Town,	State, Zip Code)			
MD 21215-0036 of 2 should be filed within 7 th and Mental Hygene. in 27 is marked other than numatic event, the Medica		Emmy Yates/ Daughter P.O. Box 208 Conowi					
re, slan fHea fiten		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - C	ity or Town, State			
altimore, mit. Pages la partment of He portant: If ite		4 Donation 5 Other Specify: Calvert Friends Cemeter	ry Rising	Sun, MD			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility R. T. Foard Funeral	cal Home, P.A. Rising Sun, MD 21				
D 52 7 1		Frank McFadden M01309 perDvr 111 S. Queen St.	Rising Sun, MD 21	911			
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card failure. List only one cause on each line.	diac or respiratory arrest, shock, or heart	Between Onset and			
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of)		Death			
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that the death certificate be executed ned by the attending physician and detached for use as the burial - transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months?		Day Year			
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. BC	چ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.	I. 23e. Did tobacco use contribu	to to the spuse of death?			
- e - e -	۵		1 Yes 2 ✓ No 3				
ds,	Completed			re autopsy findings available			
# 3 wa taga	립		performed? dea	r to completion of cause of hth?			
Re : The : The r, pag	Ŝ	25. Was case referred to medical 26.Place of Death (Cl		Yes 2 No			
lital sician is cert irecto	Be	examiner? Hospital: A Description of ER/Outraliant of Doc Other, D.	Jursing Home 5 Residence 6	Other: Scene			
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been seled in by the funeral director, page 2 should	<u>٩</u>	27 Manager of Death 28a Date of Injury 28b Time of Injury 28a Injury at More	28d. Describe how injury occurred				
On C	ion	1 Natural 5 Pending May 3, 2010 2058 hrs 1 Yes 2 ✔ No.	Driver auto fixed object col	lision			
r Atte	fica	2 V Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number of	or Rural Route Number, City			
Div ital or ral Di	Certification:	3 Suicide 6 Could not be determined (Specify) Major Road / Highway	or Town, State) 310 Love Run Road, Colora , N	/ld.			
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director,			, and due to the cause(s) and manner as	stated			
o the rithin o the smple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	rred at the time, date and place, and due	to the cause(s)			
F 5 F 3	۲į	29h Signature and title of certifier 29c License number	29d Date signed	(Month Day Year)			

30. Name and address of person who completed cause of death (Item 23a) State 31. Date lie Month Registrar

ORIGINAL

Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

May 4, 2010

Zabiullah Ali, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2<u>010</u> April Physician/ 20 4:45 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brooke Grove Sandy Spring Montgomery 8. Date of Birth (Month, Day, Year) Aug. 9, 1909 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Hours Min. Country) Director 577-01-7999 100 Wash. D.C. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md Montgomery Sandy Spring 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18131 Slade School Road 20860 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) F.B.I. Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas S. Galleher Margaretta McOuade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Regina Galleher/Niece 1831 Sutherlin, OR 97479 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 DRemoval from State April 4 Donation 5 Other (Specify) Metropolitan Crematory 2010 Alexandria, Virginia eral Service Licenses 21. Signature 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin AVe., N.W. Washington, D.C. 20007 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami or Attending Physician: The law requires that the death certificate be executed and use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Year Day Pregnant at time of death 2 No. detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Other: 2 4No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After the the Funeral Director. (Month, Day, Year) 1 Natural work? 1 Yes 2 No 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2010 05 ARUN, MD

State Registrar egistrar's Signatur

CRAAL.

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anuradha

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			Registrar 1. Decedent's Name (First, Middle)	le, Last)			imodio oi	Doum	2. Date of I	Reg. No. Death Day	Year	3. Time of Death
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1	Examir	er	4a. Facility Name (If not institutio		ımber)		4b. City, Town, o		Death		County of Death	
	Funeral	-0	Goodwill Mennor 5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	Grantsv If Under 1 Year	If Under 2	4 Hrs. 8. Date of I	Rinth	9. Birth	place (State or Foreign
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	eath w	eral	9944 Mason-Dix		cedent Ever in U	S 13 1	1555		in? (Specify Yes or	USA No- 1	A 4. Race - Americ	can Indian.
(0	r Item or Item	Funeral	11. Marital Status1 □ Never Married 2 □ Mar	Armed F	orces?		If Yes, specify Cub 1 □ Yes 2 🔀 No	an, Mexican,	Puerto Rican, etc.)		Black, White,	
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Н			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that t only one cause on	caused the deal	th. Do not ent	er the mode of dy	ing, such as o	cardiac or respirator	/ arrest,		Approximate Interval Between Onset and Death
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Ö	s after	Certification:	4 ☐ Homicide determ	buil	ding, etc. (Speci	fy)			City or	Town, State,)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical (ng Physiclan: To the I Examiner: On the and ma								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $2\overset{\text{Year}}{0}\overset{\text{ar}}{1}0$ Earle Thomas Orme, Jr. 1932 April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Frederick Calvert Calvert Memorial Hospital 5. Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🛣 M 2 🗆 F Hours Washington, DC 577-50-7835 Director 75 Usual Residence of Decedent or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland event, the Medical Examiner must be notified at Completed by Funeral Director 1X Yes 2 ☐ No MD Calvert Owings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8941 20736 USA Harmony 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc 1 ☐ Yes 2 ☒ No If Yes, Give 1 Never Married 2 K Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Specify: White 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Washington Gas Light Co 12 Investigator Be 17 Father's Name (First Middle Last 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked o 2 Margaret should be Earle Thomas Orme Irma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 8941 Harmony Ct. Owings, MD Μ. Orme Gloria Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 5/3/2010 Brentwood, MD. . Signature of Funeral Ser Licensee . 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD. 23 A art 1. Enter the cleekse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final, Physician/ disease or condition resulting in death) cute my ocard Medical Due to (or as a consequence of Examiner disease oronary actes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Physician/Medical Examiner Due to (or as a consequence of) the roscheros is the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed) 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 10 Hospital: Other: 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the f 6 Could not be Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4128 Mikalaski, mo 0038046

State Registrar

carriedal street 31. Date filed (Month, Day, Year) APR 2 9 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1000

Baltinare, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 04/24/2010 9:05P Lilly Corrine Olson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Montgomery Rockville 12031 Treeline Way Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🔽 F ğġ Months Hours Min Minnesota 577 86 2144 Director Usual Residence of Decedent show 10b. County an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD Montgomery Rockville 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20852 United States 12031 Treeline Way 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ò 🗌 Yes 2 💢 No If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: 3 ₩ Widowed 4 □ Divorced Specify: Completed White 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 lith and Mental Hygiene. 27 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) 5+ College (1-4 or 5+) Elementary/Seconday (0-12) Own Home the Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Christ Johnson Rogna Carlson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. 12031 Treeline Way Rockville, MD Douglas K. Olson/Son 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State National Crematory 04/26/2010 Falls Church, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Joseph Gawler's Sons, Inc. Washington, DC 5130 Wisconsin Ave., NW 23a. Part 1. Enter the diseas, for complications trat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. If it only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myocardial Infarction disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Atherosclerotic Cardiovascular Disease Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of, physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the attending plane of the 23c. If yes, outcome of pregnancy
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3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 7 29b. Signature and title of certifie RD8663 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ellen Reilley Farrell,

Registrar

State

31. Date filed (Month, Day, Year)

27 2010

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Records,

Division of Vital

3250 Starting Gate Court Woodbine, MD 21797

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2010 Year DAVID RUSSELL O'DELL 4:16A M May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Centr Harford Bel Air Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 🕱 2 🗆 1 1 / 4 / 1 9 5 4 New York 55 Director 089-48-9492 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland ms 23a or 28a-f sho must be notified at Director Delta York 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1184 Line Road 17314 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. Š 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ X o Specify: White Specify: Completed 3 Widowed 4 Divorced Year or Dates. 1972-75 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Finish Carpenter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental permit. Page 1 and 2 should be I Department of Health and Ments Important: If item 27 is marked any injury or other traumatic e William C. O'Dell Alberta L. Hults 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Abbie E. O'Dell/Daughter 826 N.W. Fargo Street, Camas, WA 98607 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Evans Eagle Crem. 5/3/2010 Leola, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harkins Funeral Home, Inc.,Delta, annson 23a. Part 1. Enter the disease, or control cations that caused shock, or heart failure. List only one cause on each line. cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ extic disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Rhinocerebra Mulormylosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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To the Funeral Director, After this certifica completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural 5 Pending 1 Yes 2 🗌 No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year)

May 1, 2010 29b. Signature and title of certifier D63420 who completed cause of death (Item 23a) (Type, Print) MD 500 Upper Chesapeake Drive Bel Air, MD 21014 31. Date filed (Month, Day, Year) State Registrar

M000142262

Amend 10-03191	I	tem # Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.						
	_	ecil Co State of Maryland / Department of Health and Mental 1- For State 1- For State 1- For State 1- Department of Health and Mental 1- Department of Departm	F	Reg. No. 201	0 1490			
Physici Medical Exam		, , , ,	2. Date of Dea	Day Year	3. Time of Death 0033 hrs			
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dec	April 25, 2 ath	4c. County of Dea				
		Union Hospital Elkton		Cecil				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 X M 2 F 56 Yrs. If Under 1 Year If Under 24	rth(MM/DD/YYYY) 9. B Fore 5/1953	ountry) New York				
, du		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits			
d how a	_	New Castle			1 X Yes 2 No			
arylan 8a-f si at ong	Director	Delaware Kent Smyrna 10f. Zip Code		l 0g. Citizen of What Co	45 =			
Baltimore, MD 21215-0036 pennit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Feath and Mental Hygiene, Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Dire	1040 Alley Mill Road 19977		United St	•			
r with ms 23	uneral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Drigin? (Specify Yes or No)- 14. Race - Ame	rican Indian, Black,			
death or ite	Fun	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puer 1 X Yes 2 No	rto Rican, etc.)	White, etc.				
s after ral",	by	3 Widowed 4 Divorced of Pales:			<u>ite</u>			
hour "natu	ted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of during most of working life, DO NOT use recommendations of the control of the contro	of work done retired)	16b. Kind of Business	/Industry			
336 hin 75 c. than edical	ηple	12 General Operations		Mainter	anco			
5-0C ed wit fygien other	Completed	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	me (First, Middle,	Maiden Surname)	lance			
121 De fil ental F arked	Be		hy McA11					
D 2. should and Ma	To	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Street and Number of						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than nijury or other traumatic event, the Medisa	0011	Terrence Pennell/Brother 22 University Avenue 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	, New Ca	stle, DE 1	.9720			
Ore ges 1. t of H	20c. Location - City of	Town, State						
Itim it. Pa ritmen ortant		Ap. 2 (A) Cremation 3 Removal from State Evans Cremation Service 4 Donation 5 Other Specify: Evans Cremation Service 21. Signature of Funeral Service Licensee) 22. Name and Address of Facility 22. Name and Address of Facility		Leola, I	PA			
Ba Depa Impo	W.	Hicks Home for Fu	nerals,	P.A.				
Physician		23a. Cart i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	correspiratory arr	LKTON MD est, shock, or heart	21921 Approximate Interval			
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a Multiple Injuries			Between Onset and Death			
		or condition resulting in death) Due to (or as a consequence of):						
	P.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated			La La			
ited d ansit		events resulting in death) Last Due to (or as a consequence of): d.						
760, ficate be execute g physician and the burial - tran	Physician/Medical	UNPENDED AMENDED		-				
760, cate be	Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliver	<u> </u>			
Box 68760 e death certificate b the attending physi ed for use as the bu	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregr	nancy		Day Year			
30X death death I for u	ysic	1 Yes 2 No 9 Unknown Other (Specify) Unknown						
P.O. B es that the degreed by the detached is		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?			
b, P.(d by		1 Yes	2 ✓ No 3 Prol	oably 4 Unknown			
cords, P law requires that bas been signs 2 should be de	Completed		24a. Was a autop		topsy findings available completion of cause of			
Reco	E		perfor	med? death?	· .			
Vital Reco ysician: The law his certificate has director, page 2 s	Bec	25. Was case referred to medical examiner?	k only one)					
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been sited in by the funeral director, page 2 should	2	1 ✓ Yes 2 No No No Inpatient 2 ✓ ER/Outpatient 3 DOA Other Nurs		Residence 6 Other	-			
n of oding Plant. After a funera	Ë	27. Manner of Death 28a. Date of Injury 1 Natural 5 Pending 28b. Time of Injury 28c. Injury at Work? 2140 hrs 1 Yes 2 ✓ No		now injury occurred auto collision				
isio Atter er deat rector by the	icati	2 Accident Investigation 28e Place of Injury - At home form street foctors office building stee	28f Location /S	street and Number or Ru	ral Pauto Number City			
Div ital or ral Di lled in	Certification:	3	or Town, S	tate)				
Hosp 24 hou Fune:	Table 1 20 20 Certifier C							
Fo the vithin Co the comple	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. One) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier							
- > - 3	Σ	29b. Signature and title of certifier 29c. License number		29d. Date signed (Moi	nth, Day, Year)			
		Mayorie The Shell O.C.M.E.		April 25, 2010				
10	ĺ	Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner	21201					
Str	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	41401					
Regist		APP 27 2018 Burne A. March						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Joseph 2010 Roland Proctor /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Medica Plata Charles Center La Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, 4 / 23 / 9. Birthplace (State or Foreign Country) Maryland **Funeral** ^{Year)} 1931 1**X** M 2□ F Months Days Hours Min 79 Director 218-34-5336 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County , or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinet must be confilled at once. **Funeral Director** 1 Yes 2 No Maryland Prince George Brandywine 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 10505 Cedarville Rd Lot12-28 20613 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Prince George Bd Elementary/Secondary (0-12) College (1-4or 5+) 12 Mechanic of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph R. ပ Proctor Mary L. Butler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Proctor / Niece <u> 10505Cedarville Rd,Lot12-5,Brandywine MD2061</u>B 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/6/2010 |Waldorf Maryland St.Peters Cath 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Therese MU1589 Adams Funeral home Pa, Aquasco MD 20608 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DISEASE THERO -**Physician** 70 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) □Yes 2□No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed ANCER 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an this certificate has al director, page 2: autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To i 24 hours after death. e Funeral Director: After the letely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier within 24 hor To the Fune completely fi (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0026064

State Registrar

31. Date filed (Month

DHMH 17 Rev 1/2001

30. Name and address of Jerson who completed cause of death (Item 23a) (Type, Print)

10583- THEODORE GREEN BLUD

WHITE PLAINS, MD - 20695

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 5 per inf. G904 6/3/10 dk

State of Maryland / Department of Health and Mental Hygiene - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 22, Day 2010 Year Elizabeth Т. 6:40 P M Price April Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Solomons Nursing Center Solomons Calvert 5. Social Security Number 576–22–2389 576–22–3289 If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** (Month, Day, Year) Months 1 🗆 M 2 🔀 F Davs Min. Hours Country) Director 83 Sept 1926 Hawaii Usual Residence of Deceden ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Maryland St. Mary's St. Inigoes 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 47828 Cross Manor Road 20684 United States Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2X Married 1 Yes 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced Completed Asian Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working should be filed within 72 and Mental Hygiene. 7 is marked other than "I life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Montgomery Co. Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ permit. Page 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or out. Shigeru Takayesu Yoshiko Iae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel Price/husband 47828 Cross Manor Road St. Inigoes, Maryland 20684 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Final Journey Crematory 4/26/2010 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland 21. Sign the of Funeral Service Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 ntina M00957 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Bilateral Deep Vein Thrombosis of Lower Extremities disease or condition 4 weeks Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician a be detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 2 🔀 No Yes 1 ☐ Yes ∠ ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Rheumatoid Arthritis 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Alzheimer's Dementia s certificate has the director, page 2 s performed^a Yes 2 XNo 2 No 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: Other: 힏 1 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) this eral Director: After th filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hin 24 hours a the Funeral D πpleted filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 1 D00019427 April 23, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anwar Munshi, M.D. Suite 300 130 Hospital Road Prince Frederick, Maryland 20678

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

APR 27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 4/25/2010 MYRTLE W. PATTERSON Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE'S 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 6 Sex Days 1 □ M 2 😾 F Hours Min. Director Yrs 225-12-3237 93 5/29/1916 ichmond Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Prince George's Forestville 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 2510 Newgten Ave. 20747 United States 1. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: Black "natural", 3 □ Widowed 4 □ Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. Virginia Elementary/Seconday (0-12) College (1-4 or 5+) Common Wealth Hospital 10 Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) ည Herbert White Rebecca Braxton permit. Page 1 and 2 should Department of Health and Me Important: If item 27 is man 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan P. Troublefield / Daughter 2510 Newgten Ave. Forestville, Maryland 20747 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 4/28/2010 Riverdale, Maryland Riverdale Park 21. Signature of Funeral Service Lice e Pope Funeral Home 5538 Marlboro Pike 20747 Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Betweer Immediate Cause (Final ocarelles Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify, 2 4 No 1 Tes Certificate: To 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Division of Vital Records, P.O. Box 68760

29b. Signature and title

31. Date filed (Month, Day, Year)

Krihavel

Name and address of person who completed cause of death (Item 23a) (Type, Print)

amen no

29c. License number 00055120

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Werhington DC

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			Plea	ase Type or									
			For 1 _ State	State of	Marylan		artment of H		nd Menta	al Hygier	ne 2 ()	10	14909
			Registrar 1. Decedent's Name (First, Middle	o / ast)	Certificate of Death Reg. No. 2. Date of Death 3. Time of Death								
	Physicia		M//C	bolas	Month Day Year							7:38 p M	
	Medio Examir		4a. Facility Name (if not institution	n, give street and numb	per)		4b. City, Town, o	r Location of			4c. County of		<u>1</u>
. 1			Arcola Healt				Silver			I	Montgo	mery	
	Funeral Director		5. Social Security Number 175–14–7794	6. Sex 1 X M 2 \square F	7. Age (In yrs. I	ast birthday) O Yrs.	If Under 1 Year Months Days	If Under 2		e of Birth onth, Day, Yea 24,	1919	g. Birthplace Country) Penns	e (State or Foreign sylvania
	and show at	ō	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10d.	Inside City Limits
	Maryla 28a-f	Director	Maryland	Montgomer	ry	Silver	Spring						1 🗌 Yes 2 🏞 No
	h the	al Di	10e. Street and Number				10f. Zip Code				10g. Citizen of What Country?		
	ath with	Funeral	25 East Wayne	12. Was Deced	Apt. 4		20901	iepanie Origi	n? (Specify Vac		USA	A considerate 1	
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status 1 ☐ Never Married 2 🙀 Mai 3 ☐ Widowed 4 ☐ Divorced	Armed Ford	ces? 2 X No	s? If Yes, specify Cuban, Mexican, Puerto Rićan, etc.) C No 1 ☐ Yes 2 ☐ XNo Specify:				itc.)	14. Race - American Indian, Black, White, etc. Specify: White		
5-(72 hou "natu edica	ple		nt's Education est grade completed)		(Give	dent's Usual Occup kind of work done	during most o	of working	16b	, Kind of Bus	siness Indust	ry
712	iled within I Hygiene. other thar	Con	Elementary/Seconday (0-12)	College (1-4	4 or 5+)	life. L	NOT use retired) Purchas		gent		Print	ing	
nd	filed v tal Hyg d othe event,	To Be	17. Father's Name (First, Middle,						's Name (First, I		en Surname)		
Maryland	should be file h and Mental H 7 is marked o traumatic eve		George Pilipov										
	and 2 sho Health an tem 27 is I		19a. Informant's Name/Relations Nellie Pilipov	rich/Wife	,		ng Address (Street L Cast Wayn	and Number e Aven	ue, #40	Number, City 09, Si	lver S	pring,	" MD 20901
Baltimore,	m U 4- L		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (State C	emetery, crei	osition (Name of matory or other place on Nation	al A	pri ^{Date} 29 2010	,	. Location - 0 uitlan		
alti	permit. Page Department Important: I any injury o		21. Signature of Funeral Service	icensee	1		Parred & do	ss of activ					.,
ш	<u>⊽</u> □ = 8 0	-	p for see	eus Mu							lver S		MD 20901
			23a. Part 1. Poter the disease, or shock, or heart failure. List Immediate Cause (Final	only one cause on eac	h line.				ardiac or respira	atory arrest,		Int	proximate erval Between aset and Death
	Physician/ Medical	Ĥ	disease or condition resulting in death)	a	ras a consequ		Infarcti	on					
Sacran	Examiner		Sequentially list conditions	h.									
_	d sit	nine	Sequentially list conditions, if any, leading to immediate	Due to (o	r as a consequ	uence of):							
b	executed an and rial-transit	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (o	r as a consequ	uence of):							
		cal	,	d	·	,							
976	ificate ng phy as the	Med	IF FEMALE:			-							
Box 68760	The law requires that the death certificate be executed rate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		irth 2 🗀 Feta ant at time of c	al death 3	Ectopic pregnancy					of delivery th Day	y Year
P.O.	that th	by Ph	Part II. Other significant condition	ons contributing to dea	ath but not res	ulting in the u	underlying cause giv	ven in Part I.	236	e. Did tobacc	o use contrib	oute to the ca	ause of death?
ds,	quires en sigr uld be	ed b								1 🗌 Yes	2 No 3	3 🗌 Probabl	y 4 🗌 Unknown
cor	: The law requires cate has been sig ; page 2 should b	Completed							24	a. Was an autopsy	pr	ior to comple	findings available etion of cause of
Re	The l								1 [performed Yes 2		eath?	□ No
ital	Physician: The this certificate ral director, pag	m	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:			Oth	er:	(Check only or				
)f (y Phys er this eral dii	e: 일	27. Manner of Death	28a. Date of		28b. Time of	nt 3 □ DOA f 28c. Injun	4 ✓ Nurs y at	sing Home 5 28d. De	Residence scribe how in			
ono	adh. ath. r: Afte	ficat	1 ☑ Natural 5 ☐ Pendii 2 ☐ Accident Investi	gation	, Day, Year)	injury	M 1 □	ং? Yes 2 □ N	No				
Solicide to the determined of								cation (Street or Town, Sta		or Rural Rou	ute Number,		
29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							s) and manner stated.						
	To th withir To the comp	29b. Signature and title of artifier 29c. License number 29d. Date signed (Month, Day, Year)											
	Le		· ara	Rosa			D09	834		A	pril 2	6, 20	10
			30. Name and address of person Barry Rosenbau	who completed cause Im , MD	of death (Item 3720 Fa	23a) (Type, F rragut	r _{int)} t Avenue,	Kensi	ington,	MD 20	895		
	Stat Registra	e	31. Date filed (Month, Day, Year)	010 2. Reg	gistrar's Signat	ture Sav	es.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 22 2010 Plimack Elinor 2311 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 8. Date of Birth (Month, Day, Year) May 27, 1936 Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 🗓 F Director 074-30-9485 New York Usual Residence of Decedent 10a. State ms 23a or 28a-f sho must be notified at 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Silver Spring Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3152 Gracefield Road, MS-414 20904 U.S.A ural", or items ? I Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ื No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify. "natural", 3 Divorced Year or Dates Caucasian the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) if Health and Mental Hygiene. Item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Vice President Book of the Month Club Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, is once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bee Gaibloom Emmanuel Plimack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne M. DiMarco - Cousin 5693 Adamstown Road, Adamstown, Maryland 21710 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/03/2010 Brentwood, Maryland Fort Lincoln Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinulli Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Sepsis Medical Due to (or as a consequence of): Examiner Incarcerated Small Bowel Obstruction Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or linjury <u>Aspiration Pneumonia</u> that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Corpulmonale P.O. Box 68760 IF FEMALE: signed by the attendir d be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 X No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?

1 Yes 2 X No certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Other: မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dil 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No iniury X Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ceptifier 63839 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Padma Chirumamilla,

26 2010

Month, Day, Year)

MD,

7600 Carroll Avenue, Takoma Park,

Maryland 20912

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Year Day 26, 12:00pM Robert Nelson Parlier, Sr. Apr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death E1kton Ceci1 Elkton Care and Rehab 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Birthpiace Country) DE Month, Day 1 🗓 M 2 🗆 F Months Days Hours Min Director 222-16-3185 80 1929 June Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If teem 27 is anarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No E1kton MD Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21921 USA 1234 Old Field Point Rd. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian, Armed Forces?
1 XYes 2 □ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married 1 XYes 1 ☐ Yes 2 XNo Specify: Specify: 3 XWidowed 4 Divorced Year or Dates. 1947-50 White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Computer Programmer Computer Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Samuel Parlier Bertha Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1817 Elkton, Maryland 21921 Donna Parlier/ Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5/5/2010 1 🕅 Burial 2 🖾 Cremation 3 🗌 Removal from State Delaware Veterans Mem. 4 Donation 5 Other (Specify) Cemetery Bear, DE Name and Address of Facility Foard and 59 E. Main St. Signature of Fur eral Sentice Licensee Gee Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirat N arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) rebrov Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) Month Day Year Yes 2 ☐ No 9 Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural iniury 5 Pending 2 🗆 No Accident Investigation after death Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) within 24 hours a Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

oloria Jilm 31. Date filed (Month, Day, Year)

APR 28

10+1VA

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL 2010 2:26 \mathbf{P}^{M} DORSEY DUDLEY PATCHETT, SR. Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death **OUEEN ANNE'S** 200 NEW MANOR FARM LANE CHURCH HILL Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Hours AUG. 15, 1931 MARYLAND **Director** 220-32-9630 78 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director CHURCH HILL MD OUEEN ANNE'S 1 🗌 Yes 2 😿 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 21623 200 NEW MANOR FARM LANE ed other than "natural", or items event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha AGRICULTURE **FARMER** 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ LINDA BOONE THOMAS FRANK PATCHETT, JR. item 27 is marke other traumatic should and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 200 NEW MANOR FARM LANE, CHURCH HILL, MD 21623 SALLY PATCHETT/ WIFE 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State APRIL 27, 4 ☐ Donation 5 ☐ Other (Specify) CHURCH HILL CEMETERY CHURCH HILL, MARYLAND 2010 Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
408 S. LIBERTY ST., CENTREVILLE, MD 21617 Thech & D 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence oi) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury use as the burial-tran the attending physician and that initiated events Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ģ Month Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an After this certificate has director, page 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) completed filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending 2 🗆 No Accident Investigation 24 hours after deat Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one HOUS 7821 2540 Centremile Name and address of person wh o completed cause of death (Item 23a) (Type, Print) remite 21617

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

APR 27

Registrar's Signature

Please Type or Print Black Indelible Ink. State of Mary d / Department of He	Ensure All Copies Legible ealth and Mental Hyg
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	1- For State Control Certificate of Death Reg. No. 2010 149
Physician/	Registrar 1. Decedent's Name (First, Middle,Last) 1. Decedent's Name (First, Middle,Last) 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year March 20, 2010 1. 129 hrs
1 Examiner	JATES As County of Death
	4a. Facility Name (if not institution, give street and number) 7 Cedarburg Court #A 4b. City, Town, or Location of Death Parkville Baltimore County
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYYY) 9. Birthplace (State or Foreign
Funeral Director	213-86-1905 1X M 2 F 40 Yrs. Months Days Hours Min. APR 11, 1969 Country D.C.
	Isual Residence of Decedent
any	10a. State 10b. County 10c. City, Town or Location 10d. Mary LAND BALTIMORE CITY BALTIMORE
Aaryland 28a-f show 1 at once. ector	Late 7: Code 100 Citizen of What Country?
he Maryland or 28a-f sh iffied at once	7 A CEDARBURG CT. APT. A (PARKVILLE) 21234 UNITED STATES
death with the Maryland or items 23s or 28s-f sho must be notified at once-uneral Director	14. New Decedent Fuer in U.S. 113. Was Decedent of Hispanic Origin? (Specify Yes or No-
or items 23 must be no Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
	3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: Specify: Specify: Visit of Divisions (Individual Property of Dates)
natura Xamii	45 Decedent's Education (Specify only highest grade completed) Total Decedent's Osdar Occupation (Specify only highest grade completed)
0036 within 72 hours giene. her than "natu Medical Exan	Elementary/Secondary (0-12) College (1-4 or 5+) PROJECT MANAGER COMMUNICATIONS
J withi	17, 1 dulor o reality (med miner) = 7
21215-0036 Juid be filed within 72 hours after death with the Maryland Mental Hygiene. Mental Hygiene. marked other than "natural", or items 23a or 28a-f ah ite event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	PHILLIP CHARLES POSTON JOY JAMES PANTAZIS
D 21215-00: should be filed with and Mental Hygiene r is marked other t stic event, the Me To Be Com	17640 POINTER DR #P1 LEWES, DELAWARE 19958
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after near of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or other transatic event, the Medical Examiner. To Be Completed by I	20b Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
Ore, ses lan of He If ite	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State BETHEL CEMETERY MAR 25,2010 LEWES, DE 19958
Baltimore, permit. Pages I a Department of He Important: If ite	4 Donation 5 Other Specify: 23 Name and Address of Facility 19966
Baltimore, MC pernit. Pages I and 2 s Department of Health a Important: If iten 27 injury or other traum	MO 1361 WATSON FUNERAL HOME PU BOX 125 MILLISBORG, DE
?hysician	233. Part I. Enter the diseas and or complete tions that caused the death. Do not enter the mode of dyling, such as cardiac or respiratory shows the diseas and failure. List only one cause on each line.
Medical.	Immediate Cause (Final disease a Hypertensive cardiovascular disease
THE EXAMINET	or condition resulting in death) Due to (or as a consequence of): b.
2	Sequentially list conditions,
The sample of th	cause. Enter Underlying Cause (Disease or injury that initiated C. Due to (or as a consequence of):
In ansit of the second	events resulting in death) Last Due to (or as a consequence or). d.
e exect sian an rial - tr	X UNPENDED AMENDED 23a, PII, 27, per ME G903 5/13/10 TT
Records, P.O. Box 68760, The law requires that the death certificate be executed icate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23d. Date of delivery 4 Nonth Day Year
68 certifi anding use as t	23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of death 5 Other (Specify)
Box death he atte	1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death?
P.O.	1 Yes 2 No 3 Probably 4 V Unknown
S, P	Chronic alcoholism 24a. Was an autopsy findings available prior to completion of cause of
Records, I The law requires ficate has been sig , page 2 should be	autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Rec The la	26.Place of Death (Check only one)
cian:	25. Was case referred to friedical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene
Division of Vital Records, P.O. B pital or Attending Physician: The law requires that the drouts after death. Iteral Director: After this certificate has been signed by the filled in by the funeral director, page 2 should be detached	1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred
anding ath.	1 X Natural 5 Pending Investigation Investigation 2 Accident Investigation Investigati
vision Atterder der in by t	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Div pital o ours ad ceral D	determined (Specify)
9.0	
To the within To the comp	and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier
	O.C.M.E. OCME March 21, 2010
	30. Name and address of person who completed cause of death (Item 23a) Theodore M. KingIr. MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
	Theodore W. Tung, S., M.S.
Sta	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician 25, 2010 2:45 P Helga A. Rodgers April /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick Myersville 2943 Ward Kline Road Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours 1 □ M 2 □XF Director 218-90-1771 62 May 18, 1947 Germany Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Executions in the contract of t 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County 1 ∏Yes 2√2 No Director Maryland Frederick Myersville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2943 Ward Kline Road 21773 Germany Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Ye ar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) <u>Agriculture</u> Personal Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Albert Wex (unk) 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2943 Ward Kline Road Myersville, Maryland 21773 Philip E. Rodgers/husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 4/27/2010 Woodbine, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M00957 Thomas Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Me SIR h disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Exam attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the 1 ☐ Yes 2 ☑ No 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed this certificate h 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi 28a. Date of Injury (Month, Day, Year) 28b Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? the Hospital or Attending 1 Natural 5 ☐ Pending investigation To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a, Certifier 1/C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

41667

Compu.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5, per Inf G903 5/13/10 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ April 22 0542 Marion Reese Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Shady Grove Adventist Hospital Rockville If Unde If Under 24 Hrs 059 Seguzty 94737 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** New York 1 🗆 M 2 🏋 F Months Davs Hours Min (Month, Day, Year) Director 81 Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Montgomery Gaithersburg 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 19306 Kildonan Drive 20879 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 Widowed 4 Divorced Completed White Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper High School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Clarence Moss Fdith Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Harper/daughter 19306 Kildonan Drive Gaithersburg, Maryland 20879 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) inal Journey Crematory 4/24/2010 Woodbine, Maryland 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M mante R Homas M00957 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ Ventricular Fibrillation disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Hypotension Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) that the death certificate be executed iis certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9X Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 21 No Hospital or Attending Physician: 25. Was case referred to medical B 26. Place of Death (Check only one) examiner?
1 Yes 2 XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Director: After this completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27, Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 🗷 Natural injury 5 Pending 1 🗆 Yes 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 24 hours after of Funeral Direc determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 3 29b. Signature and title of certifier 29c. License number ٥ 29d. Date signed (Month, Day, Year) D0067512 April 22, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bangalore Madan, M.D. 9901 Medical Center Drive Rockville, Maryland 20850 APR 2 31. Date filed (Month. 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2010 Year 2:40 Рм Annie Novella Reid 21 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 509 Graydon Lane Fruitland Wicomico If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√□ F Days 217-30-7619 Director 84 Feb 23, 1926 VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Director traumatic event, the Medical Examinar quat be notified Yes 2 □ No MD Wicomico Fruitland 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 72 hours after death with 23a 509 Graydon Lane 21826 USA Funeral items 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian, Black, White, etc 1 ☐ Never Married 2 ☐ Married 0 African-Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify. ģ 3 XWidowed 4 ☐ Divorced "natural", American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) 7th College (1-4or 5+) Hygiene. permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other that any injury or other traumatic event, the once. Domestic Various 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Wilmore Stevens Clara Harmon ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Regina Badger/daughter 510 Graydon Lane, Fruitland, MD 21826 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Springhill Memory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/26/2010 Gardens Hebron, MD 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 1618 West Road, Salisbury, MD 21801 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PNE UMONIA Immediate Cause (Final **Physician** disease or condition resulting in death) UNKNOWN /Medical Due to (or as a consequence of): Examiner END. STAGE PULMANARY FIBROSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events NKNOWE Examiner Due to for as a consequence of requires that the death certificate be executed DEMENTIA Due to (or as a consequence of): and burial-trar UNKNOWN resulting in death) Last Box 68760 Physician/Medical the use as IF FEMALE ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 5 Other (specify) Ö detached 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ✓ No 3 ☐ Probably 4 ☐ Unknown FAILURE TO THRIVE PROTEIN MALNUTRITION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed certificate 2 No 1 □Yes 2 No Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Medical Certification; To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manger of Death 28d. Describe how injury occurred After or Attending 1 Natural 5 ☐ Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No filled in by the within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MO 6 m 050929 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADARANG-LEWIS DIVISION ST. SALISBURY MD 1405 egistrar's Signatu 31. Date filed (Month, Day, State **APR 28** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 24, Day 2010 Year **Physician** Dorothy C. Ruhf 6:00 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arcola Health & Rehab. Center Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) Oct. 8, 1925 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖰 F Months Days Hours 032-12-2859 84 Massachusetts Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with .0304 Edgewood Avenue 20901 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 2 3x Widowed 4 □ Divorced "natural", er than "nature, Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Homemaker Own Home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental marked George Albert Opitz Carolina Maier 7 is marker traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 10304 Edgewood Avenue, Silver Spring. Thomas E. Ruhf/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o April 2010 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 22 Name end Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee on Kle 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician (on estive /Medical Due to (or as a consequence of): Examiner Coroner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical as ettending for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the e 5 Other (specify) 1 ☐ Yes 2 ☐ No o∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed certificate 2 € No 1 ☐ Yes 2 ☑ No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pleath.
within 24 hours efter death.
To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death After 1 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 🗷 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

State

elect

SHARMA

26 2010

SANDEEP

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUMMER

2. Registrar's Signature

29c. License number

DO064624

WALK DR. GALTHERSBURG, MD

29d. Date signed (Month, Day, Year)

APRIL 24, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1:37 PM Ruth Ryan Loretta Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 17900 Williams Road Allegany Flintstone Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD 8. Date of Birth 7. Age (In yrs. last birthday **Funeral** Days Hours Min 1 🗆 M 2 🗔 Dec 21 215-26-7027 **Director** 81 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Flintstone MD Allegany 1 🗘 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17900 Williams Road 21530 USA ral", or items? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: 3 Widowed 4 Divorced white Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natur jury or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Ronnie's Glass Shop co-owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ William Zedick Wilt Lora Alice (Broadwater) Wilt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 17900 Williams Road Flintstone MD Ronald Ryan MD 21530 husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 K Burial 2 Cremation 3 Removal from State Restlawn Memorial Gardens 5/3/2010 MD 4 ☐ Donation 5 ☐ Other (Specify) LaVale 21. Signature of Juneral Service Lognses 22. Name and Address of Facility PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Pp. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) a Neuroendocrine metastatic Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the extending the control of the contr Cause (Disease or iinjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year ate has been signed by the a page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforn death? 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 Tes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or/investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signa ture and tit 29d. Date signed (Month, Day, Year) 23371 s of person who completed cause of death (Item 23a) (Type, Print) ZAMAN M. RD. STE440 CUMBERLAND, MD 21502 AMAR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

34

10-03353 Keith C. Riland Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

eim C. Kiland		State of Maryland / De	Certificate of		u wentan i		2016	
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	Jertineate of	Death		2. Date of Dea	eg. N o. th	3. Time of Death
/ledical Exami	.1117	Keith C. Riland				Month May 1, 20	Day Year 10	1712 hrs
***		4a. Facility Name (if not institution, give street and number)	4	b. City, Town, or	Location of Deatl	1	4c. County of Deat	h
		Frederick Memorial Hospital		Frederick			Frederick	
Funeral		5. Social Security Number 6. Sex 7. Age (In y	rs. last birthday)	If Under 1 Year Months Day			th(MM/DD/YYYY) 9. Bi Forei	gn
Director	- 1	212-84-1399 1x M 2 F 48	Yrs.	Mondis Day	5 Hours Will		6,1961 c	ountry)Maryland
*		Usual Residence of Decedent	City, Town or Location					10d. Inside City Limits
w any		10a. State 10b. County 10c. (Jity, Town of Locatio	OH				1 X Yes 2 No
/land -f sho	rector	Maryland Frederick F 10e. Street and Number	rederick	10f. Zip Code		T ₄	Og. Citizen of What Co	
ith the Maryland 23a or 28a-f show notified at once.	<u>i</u>			· ·				
ith the	a Di	2100 Foxfield Circle 11. Marital Status 12. Was Decedent Ever i	in II S 12 Way		702 spanic Origin? (S	pacify Vac or No	United S	rican Indian, Black,
ath w	neral	1 Never Married 2 X Married Armed Forces?	If Ye		n, Mexican, Puerto		White, etc.	ricar indian, black
ter de	Fune	1 Yes 2 X N 3 Widowed 4 Divorced If Yes, Give Year		Yes 2 X No	specify:		Specify: Wh	ite
hin 72 hours afte e. than "natural",	d b	15. Decedent's Education (Specify only highest grade completed			tion (Give kind of		16b. Kind of Business	
72 bo	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during mo	ost of working life	e. DO NOT use ret	irea)		
5-0036 iled within 7 Hygiene.	m d	2	Govern	ment Pr	ogram Ma	nager	AT & T	
5-0 iled v Hygi dother the l		17. Father's Name (First, Middle, Last)					Maiden Surname)	
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at once	Be	Stephen Phillip Riland	10b Mailing	Address (Strat		lores S	mith nber, City or Town, Stat	e Zin Code)
MD 2 d 2 shoul lith and M n 27 is m	٩	19a Informant's Name/Relationship (Type, Print) Jacquelyn Carole Jones—Riland Logovalus Biland/ Hife					ck,Maryland	
	ŀ	Jacquelyn Riland/ Wife 20a. Method of Disposition 2:	Ob. Place of Disposi	tion (Name of ce		Date	20c. Location - City o	
Baltimore, permit. Pages I ar Department of Hee Important: If ite Injury or other tr		1 Burial 2 X Cremation 3 Removal from State	crematory or oth	. ,	_ _	/r /2010	Tin . 1 1	Wa1 a d
Itimen ritmen y or o		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee					Frederick	
Ba Perm Depa injur	I	Jadel D(Newell)		uffer F	uneral H	lomes P. like. Fr	A. ederick.Maı	yland 21702
Physician		23a. Part I. Enter the disease, or complications that caused the de	eath. Do not enter th	e mode of dying,	such as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval
Medical	: 4	failure. List only one cause on each ine. Immediate Cause (Final disease a. Hypertrophic	c atheros	clerotic	cardio	ascular	disease	Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence						
	L	Sequentially list conditions, b						
	ia	If any leading to immediate cause. Enter Underlying Cause Classes of Underlying Cause C.	ce of):					
-	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence)	ce of):					
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit		d						
be execician	Medical	X unpended 19a, per FH	, 23a, 27	, per MH	E g903 5	/20/10 I	T	_
760, Icate be physiciate buri		IF FEMALE: 23c. If yes, outcome of p	pregnancy				23d. Date of delive Month	ry Day Year
certif	Sia	23b. Was decedent pregnant in the past 12 months?	- f - d	al death 3	Cctopic pregn	aricy	Mortan	Day Toda
Box 687 death certific the attending p	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	- Cu	101 (+1)				
O. at the d by t		Part II. Other significant conditions contributing to death but r	not resulting in the ur	nderlying cause	given in Part I.		obacco use contribute to	green't a
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transitions.	d by					-		obably 4 🗸 Unknown
ords, w requir s been s should	Completed					24a. Was autop		utopsy findings available completion of cause of
ecol he law ate has age 2 sl						perfo 1 ✓ Yes	rmed? death? 2 No 1 ✓ Y	res 2 No
tal Rectan: The certificate ector, page		25. Was case referred to medical			e of Death (Check			
Vits ysicia this co	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatient	3 DOA	Other Nursi	ng Home 5	Residence 6 Othe	er:
n of Vit ding Physic 1. After this funeral dir	=	27. Manner of Death 1 X Natural Deading 28a. Date of Injury (Month, Day, Year)	28b. Time of Ir		ıry at Work?	28d. Describe	how injury occurred	
	턃	1 A Natural Ponding 2 Accident Investigation			Yes 2 No			
Division of Vital Records, pital or Attending Physician: The law require ours after death. reral Director: After this certificate has been si filled in by the funeral director, page 2 should b	Certification:	3 Suicide 6 Could not be 28e. Place of Injury -	At home, farm, stree	t, factory, office t	building, etc.	28f. Location (or Town, 8		ural Route Number, City
Di Hospital 24 hours s Funeral etely filled	9	4 Homicide determined (Specify)						
Divisior To the Hospital or Attend within 24 hours after death, To the Funeral Director: completely filled in by the:		29a. Certifier (Check only one) Certifying Physician: To the best of my know one) Wedical Examiner: On the basis of examinating	wledge, death occurr on and/or investigati	red at the time, d ion, in my opinior	ate and place, and n, death occurred	d due to the caus at the time, date	se(s) and manner as sta and place, and due to t	ned. he cause(s)
To the within To the comple	Medical	and manner stated. 29b. Signature and title of certifier		29c. Licens			29d. Date signed (M	
		ano D		O.C.			May 3, 2010	,
		30. Name and address of person who completed cause of death ((Item 23a)				<u> </u>	
		Ana Rubio MD. Assistant Medical Examiner		treet, Baltim	ore, MD 2120	1		
S	tate	31. Date filed (Month, Day, Year) 32. Registrar's Sig		Kel				
Pagis		MAT D ZUILI Cleaning	Fel . 26.90 64	Contract of the Contract of th				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Day Month Physician/ SCHMIDT 20 HELEN JANE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 2, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 XM 2 D F 361-20-8659 1919 Illinois Director 91 Usual Residence of Decedent show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No Adamstown Maryland Frederick 10g, Citizen of What Country? 10e Street and Number 10f. Zip Code Funeral United States 21710 3103 Chartwell Crecent Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes Give "natural", 3 Divorced Completed White Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) the Medica1 <u>Social Worker</u> event, Be 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be filed tment of Health and Mental Hy tant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) pernit. Page 1 and 2 should be f Decartment of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Margaret Riley Joseph Dessero 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 3103 Chartwell Crecent Ln., Adamstown, MD 21710 Joseph Schmidt / Husband 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) Frederick, Maryland 4/26/2010 Stauffer Crematory 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 23a. Pa the the diseas implications that caused by thath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List inly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions: Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No ğ Month Year Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached to Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No this certificate 25. Was case referred to medical within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) Certificate: To Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 1 🗌 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury_at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending work? 2 🗌 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Tertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 4-23-10 D0058726

State Registrar 30. Name and address of

31. Date filed (Month, Day, Year)

MO

Myersville

erson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Lennen

Ct.

Ventrie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 11.021

		•	State Registrar		Ce	ertificate	of L	Death			Reg. No.	2010	1 4	741
	Dhysisi	2.0	1. Decedent's Name (First, Middle, I	.ast)		Month					Date of Death 3. Time of Death Month Day Year Ca53			
	Physicia /Medic		Donna Mae Sny	der		Apri					1 28 2010 6:51 A			Ам
	Examin	er	4a. Facility Name (If not institution, g			4b. City, Town, or Location of Death					4c. County of Death			
-			16730 Virginia					liams		0 D : (D)			ington	
	uneral			Sex 7. Age (In	yrs. last birthday 65 Yrs.	Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da August	th ly, Year) 21 1 C	9. Birti	hplace (State o	_
	Director		216-42-1937 Usual Residence of Decedent						¥	Hugust	31/13	744	Marylan	iu
land	MO #		10a. State 10b. County	100	c. City, Town or L	ocation							10d. Inside Cit	y Limits
Mary	-fs-	ţō	Maryland Washi	ngton		TA7:11	iame	sport					1 □Yes	No XX
the	r 28e	Director	10e. Street and Number	ngcon		10f. Zip		<u>por c</u>			10g. Cltize	en of What Co	untry?	
h witl	23a o st be		16730 Virginia	Avenue			2]	1795				US	A	
deat	ema 2	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13	Was Decede			rigin? (Spe	ecify Yes or No Rican, etc.)	- 1	4. Race - Ame	rican Indian,	
after	or ite	F	1 Never Married 2 Married			1 ☐Yes 2		Specify:		riloari, cic.)		Black, White Specify:	, etc.	
21215-0036 of within 72 hours aft	Iral",	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:									White	
727	"nati	lete	15. Decedent's (Specify only highest of	Education grade completed)	16a. Dec	edent's Usua e kind of worl DO NOT use	l Occupa k done d	ation during mos	st of workir	ng	16b. Kind 	d of Business/I	Industry	
章 章	than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	I	wner/0					_	Pest Co	ntrol	
d o	ther int, t		17. Father's Name (First, Middle, La	st)		wiict/ O	PCLC		er's Name	(First, Middle			IICLOI	
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland	sed o) Be	Ralph E. Knig					Dor		Elizabe				
Noulk	mark mati	유	19a. Informant's Name/Relationship		19b. Mai	ing Address	(Street a					Town, State, Z	Zip Code)	
X 26	27 is		Jim Snyder - Hu			-							yland 2	1795
s 1 a	item othe		20a. Method of Disposition	2	Ob. Place of Disp	osition (Nam	e of	0)		ate		ation - City or		1700
Baltimore, permit. Pages 1 ar	Department of Health and Mental Hygiene. Important: If item 27 is marked other than. Important: If item 27 is marked other than. Important: If item 27 is marked other than you in the Madical Examination of the number of the nu		1 ☐ Burial 2 ⚠ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐ Removal from State	lagersto			i	oril 2	9,2010	Hager	stown	Marvla	nd
mit.	partn porta y inju		21. Signature of the grant Service Lin							e, P.A.		DCOM11,	riol y Eu	
m 8.	8 E E 8		1 Sittel	SV_	4	25 S.	Conc	coch	eague	e St. W	illia	msport	, MD 21	795
			23a. Part 1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the	death. Do not e	nter the mode	e of dyin	g, such as	s cardiac o	or respiratory a	ırrest,		Approximate Interval Bet	ween
Phy	ysician		Immediate Cause (Final disease or condition	Carlina	e l mom	ann	1	nest	2			1	Onset and I	Death
	Medical		resulting in death)	Due to (or as a	nsequence of):	0								
Ex	aminer		Sequentially list conditions.	b. Respe	water	Fail	us	2						
pa	sit	ine	Sequentially list conditions, if any, leading to in reduct cause. Enter Underlying Cause (Disease or injury that initiated events	Only to (or N s a co	nsequence	J.	0 1	20		Ω	*	0		
xecut	and I-tran	Examiner	that initiated events resulting in death) Last	c. Chronic Due to (or as a co	nsequence of):	uctw		July	nera	y Du	2000	0_		
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687	g phy:	Medical		d										
o cert	attending p for use as t		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr							2	3d. Date of del	ivery	
. Bo	e atte d for	icia	in the past 12 months? 1 □Yes 2 ②No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	e of death 5	☐ Ectopic pr ☐ Other (spe		у				Month	Day	/ear
P.O	been signed by the should be detached	Physician	g □ Unknown	9 Unknown										
S, L	gned se de	by P	Part II. Other significant conditions	contributing to death but no	ot resulting in the	underlying ca	use give	en in Part i	i.				the cause of d	
Records, se law requires th	en si ould b									1 🗆	Yes 2 🗷	UNo 3□ Pr	obably 4 🗆 l	Jnknown
ecc law r	2 83	ple								24a. Was		24b. Were au	topsy findings	available ause of
E PE	ate	Completed								perfo 1 □Yes	ormed?	death?	2 □No	
Vital	certificate rector, pag	Be (25. Was case referred to medical examiner?	1			1		e of Death	(Check only	one			
ohysi	.ω . . . Ξ	၉	1☑ Yes 2☐ No		2 ER/Outpati			4 🗆 🗥				☐Other (Spe	cify)	
Division of	fter	ioi	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Ye.	ar) 28b. Time Injury		Bc. Injun Work	yat ⟨? Yes 2□		28d. Describe	how injury	occurred		
Sich	tor:	icat	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	be	At home farm s			res 2 L		28f Location (Stmot and	Number or Pr	ural Route Num	her
Div Jera	s after death. al Director: A ed in by the fu	Certification:	4 ☐ Homicide determine	28e. Place of Injury - building, etc. (S	Specify)	iroot, laotory,	omoo			City or To		Wamber of The	arar riodic rion	<i></i>
Division of Vita	e Funeral D			Physician: To the best of m										
e Ho	ne Fu	edical	(Check only one) 25 Medical Ex	aminer: On the basis of exa and manner stated.	amination and/or	investigation,	in my o	pinion, de	ath occurr	ed at the time	date and	place, and due	to the cause(s	;)
Tot	To the comple	ž	29b. Signature and title of certifier	10 1	0	29c.	. License	e number				signed (Mont		
			Momest (2	best m. D.O.	FACET		44	088	4		04	28,2	2010	
ا المالية المالية	-6		-th	o completed cause of death ext 75 25 32. Registrar's 3	(Item 23a) (Type	, Print)	C	1/		,	4.5	2 11		
500	/		31 Date filed (Month Day Year)	ert TI 25	IE. Ant	ietam	8t.	Hag	erst	own n	nD.	21740		
	Sta Registr		APR 29	2010 Sz. registrars	Signature	back	•	-						
DIMAL	17 Dec 4/2	201		TO ASSOCIATE	P. 19									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ 2010 11:15 A^M Joseph Eugene Shilling Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Autumn Assisted Living Hagerstown Washington Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 **X** M 2 □ F Hours Jume^{th,}Pi^{y,}, Year 931 Maryland 78 216-22-7647 Director Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10a. State Funeral Director 1 X Yes 2 □ No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? and Mental Hygiene.
is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be a U.S.A. 1112 W. Church St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married 1 X Yes 2 □ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Shoe Maker Shoe Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည be f Orpha Louise Bowman Maynard Leon Shilling and 2 should to the alth and Me tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1112 W. Church St., Hagerstown, MD Beulah L. Shilling/Wife item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State Cedar Lawn Mem. Park | 5/1/2010 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 5. Man 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysiciani Melentitie 2 2 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year Day ate has been signed by the page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Alphin's Dinear 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 40 4 Nursing Home 5 Residence 6 Other (Specify ASSISTED LIVING မ 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral c 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Natural 5 Pending To the Hospital or Attendia
within 24 hours are death.

As the Funeral Director A
completed filled in by the for 1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗓 🖙 Gerlifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b, Signature and title of certifier -atmo APRIL 28,2010 0 (8019 1 DA

Registrar DHMH 17 Rev 7/2009

State

VASALTI

31. Date filed (Month, Day, Year)

NACE RESTOUD ND Q1740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DATTA MO 340 MILL ST.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	of Maryland / Depa				0.5	110	11000	
			T = State Registrar Certificate of Death Reg. No. 2								
	Physicia			Year	3. Time of Death						
	Medic		Giancarlo Lino Soviero 4a. Facility Name (If not institution, give street and nu	mher)	4b. City, Town, or Lo	acation of Death	4		010	2:25 P ^M	
	Examin	er	39 Seafarer Lane Berlin						4c. County of Death Worcester		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year II	Under 24 Hrs.	8. Date of Birt	h		place (State or Foreign	
	Director		579-08-2385 1 № 2 □ F	44 Yrs.	Months Days	Hours Min.	(Month, Day	(Yea <i>r</i>)	NY NY	try)	
	d ow		Usual Residence of Decedent 10a, State 10b, County								
	ryland -f sh ied a	cto		10c. City, Town or Lo	cation				'	0d. Inside City Limits	
	e Ma r 28a notifi	Director	MD Worcester 10e. Street and Number	Berlin	10f. Zip Code			10 011 1		1 Yes 2 No	
	ith th	rall	39 Seafarer Lane		,			10g. Citizen of	wnat Coun	_ountry r	
	ath w	Funeral		edent Ever in U.S. 13.1	21811 Was Decedent of Hispa	anic Origin? (Spec	cify Yes or No-	USA 14. Bac	e - Americ	merican Indian,	
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 X Never Married 2 Married Armed F	2 🔀 No	f Yes, specify Cuban, N 1 ☐ Yes 2 😾 No S		Rican, etc.)	Bla	ck, White,	etc.	
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Nar	should be file h and Mental I 7 is marked o traumatic eve		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and	Number or Rural	Route Number	; City or Town, S	State, Zip C	lode)	
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סכ	Page 1 anent of Hant: If ite		1 Burial 2 Cremation 3 Removal from	11 Otato	natory or other place)		ate	20c. Location	- City or To	wn, State	
Baltimore, Maryland 21215-0036	permit. Page Department Important: Il any injury or		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Librensee		opean Crem 2. Name and Address of	4/26	Contract of the Contract of th	rankfor			
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<u> </u>	Physician: T r this certifica ral director, p	To B	examiner? 1 Yes 2 No Hospital:	Inpatient 2 ER/Outpatier	nt 3 DOA Other:	4 Nursing Hor	ne 5 🔀 Resid	ence 6 🗆 Oth	er (Specify))	
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ion	tendil leath. or: Af the fu	ifica	3 Suicide 6 Could not be		M 1 🗆 Yes	s 2 □ No					
building, etc. (Specify)							28f. Location (S City or Tow	treet and Numb n, State)	er or Rural	Route Number,	
_	lospita 4 hours uneral ed filler	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	the L thin 24 the F mplet	Me								ated.	
_	5 4 × 6		29b. Signature and title of certifier		29c. License nu	66462	1	29d. Date signe		vay, rear)	
			30, Name and address of person who completed cau			-		4-26	10		
	ET 5		Jeffrey R. Scheirer DO	, , , , , , ,	,	nit C. B	erlin.	MD 2181	1		
	Stat		31. Date filed (Month, Day, Year) 32.	Registrar's Signature							
	Registra	ar	APR 2 7 2010	wer S. A	arke						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 24a per phys. 6904 6/3/16 opies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2010 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRIL 24, Day 2010 Year Physician/ Spiker 14:25 Charles Robert М Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALLEGANY CUMBERLAND WMHS - REGIONAL MEDICAL CENTER 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1**₹X**M 2 ☐ F 60 Hours Min. July 5 1949 Maryland Director 220-52-9459 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits within 72 hours after death with the Maryland Director Allegany Westernport MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21562 202 United States St. Wood Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black White etc. þ 1 Never Married 2XXMarried Saltimore, Maryland 21215-0036 Specify: white If Yes, Give Vietnam Year or Dates. 1 Yes 2XXNo Specify: "natural", Completed 3 Divorced Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meone. Elementary/Seconday (0-12) College (1-4 or 5+) Veterans Club Custodian Be filed \ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I ည Elva Wilt Spiker Raymond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 202 Wood St, Westernport, Maryland 21562 19a. Informant's Name/Relationship (Type, Print) Connie Spiker/ wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 04/2^{Date}/2010 cemetery, crematory or other place)
MD Veterans Cemetery Burial 2 Cremation 3 Removal from State Flintstone, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mole of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Onset and Death Immediate Cause (Final Physician/ erebrak disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Examir use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? for Month Day Year Pregnant at time of death been signed by the sahould be detached 9 Unknown a Linknown Hospital or Attending Physician: The law requires that the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 1 Yes 2 No this certificate 1 Yes 2 No **Division of Vital** funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 🔽 No 1 Yes ၉ 1 Depatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident work? injury 5 Pending Investigation 3 Suicide 6 Coale e of Injury - At home, farm, street, factory, office ding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, term bu City or Town, State) Medical siciar. To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Certifying P 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mohth, Day, Year) 26 D23167 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person wh 12502 WILLOWBROOK ROAD, SUITE 670, CUMBERLAND, MD 21502 M.D ARRISUENO Day Yar 2 7 2010 Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Physician/ 2010 Gertrude Elizabeth Spriggs 5:04 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Cente Prince George's Cheverly 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** Months Davs Hours 01/06 1 □ M 2**X** 83 Esmont, Va Director 137-22-8151 1927 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 🔀 Yes 2 🗌 No D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4623 Hunt Pl., N.E. 20019 U.S.A. ıral", or items ? I Examiner mus 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. ş 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 African-1 ☐ Yes 2X No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates American permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Healthcare 10th Nurses Aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph P. Brown Lottie Carey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila Delaney/Daughter 10733 Campus Way So., Upper Marlboro, Md. 20c. Location - City or Town, State 774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Olivet Cem. 04/30/10 4 Donation 5 Other (Specify) Mt. Washington, D.C. Signature of Funeral Service Licensee ^{22. Name and Address of Facility}
H.S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E., Washington, D.C. an 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approxima e Interval Between Onset and Death Immediate Cause (Final Physicianz <u>Arrhythmia</u> disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed COPD and burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death☐ Pregnant at time of death 3

Ectopic pregnancy in the past 12 months? for Dav Year Month 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate ! 1 ☐ Yes 2 🗷 No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 1 ☐ Yes 2 🗷 No မ 1 Inpatient 2 X ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 28b. Time of injury 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending X Natural after death. Director: Af 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Rcute Number, 4 Homicide completed filled in by determined City or Town, State) 24 hours Funeral Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and of a Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and results of the cause of Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the lawithin 2 29b. Signature and title ed (Month, 3

Registrar

State

nd address of person who completed c

.0.

31. Date filed (Month, Day, Year)

APR 2 8 2010

CUMBERBAYCH

<u>Hospital</u>

Dr.

.Cheverly.Md

20785

se of death (Item 23a) (Type, Print)

32. Registrar's Signatur

M.D.3001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Eloise Stone 8:00 P. M April 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Villa Rosa Nursing Home Mitchellville Prince Georges 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year 24) Months Days Min. Year) 1 M 2 XF Hours 78 Director 577-42-2120 Washington, D.C Nov. Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director MD Prince Georges Mitchellville Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3800 Lottsford Vista Road United States hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No Black White, etc. ğ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes Give Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Service Home Care Giver Be 17 Father's Name (First Middle Last. 18. Mother's Name (First, Middle, Maiden Surname) ൧ Albert Parker Maud Wills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ella Stone/ Daughter 7501 Mandan Road, #202, Greenbelt, MD Baltimore, 20a. Method of Disposition April 22 2010 20b. Place of Disposition (Name of 20c. Location - City or Town, State Geo. Wash. University 1 🗆 Burial 2 🗆 Cremation 3 🗆 Removal from State Washington, D.C. 4x Donation 5 ☐ Other (Specify) Medical Center 22. Name and Address of Facility Columbia Mortuary Services, P.A. Signatur of Funeral Service Licensee /M00969 9013 Annapolis Road, Lanham, MD 20706 AZ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine Dise to for as a consequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events sician and burial-trans Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical certificate be Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ĺ Month Day Year detached g Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 Yes 2 No Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death. To the Funeral Director: After this filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending 1 Natural 5 Pending work? 1 🗌 Yes 2 🗌 No ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only qu 29b. Signat and title of 29c. License number 29d. Date signed (Month, Day, Year) D32261

Registrar

State

30. Name and address of person

Good Lock M

who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signa ure

938116

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ HELEN C SIMMS 04 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** OCT. 6, 1921 1 □ M 2 🔀 F Months Hours 88 Frederick, MD Director <u>231-22-8486</u> Usual Residence of Decedent or 28a-f show e notified at 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director DC Washington 1 X Yes 2 No None 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? "natural", or items 23a o Funeral 20011 4310 2ND Street, USA NW 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.] þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 SpeBlack 1 Yes 2 XNo Specify: If Yes, Give 3 XWidowed 4 ☐ Divorced Completed Year or Dates and Mental Hygiene.
Is marked other than "natur aumatic event, the Medical I 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill the should be fill the should be fitten 27 is marked a other traumatic events. Wesley Saunders Ceaser Nellie Virginia Ambers Ceaser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Thompson / Daughter 712 71st Ave., Seat Pleasant, Maryland 20743 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State Rock Creek Cemetery | 4-30-2010 Washington, DC 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lyles Funeral Service 21. Signature of Funeral Service License P.O. Box 397, Purcellville, Virginia 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a Intracrana disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and Cause (Disease or injury that initiated events the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🔀 No
9 ☐ Unknown Month Day signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Aneurysin 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State, Medical 29a. Certifier Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner To the best of my knowled at the time date and sk 29b. Signature and title of certifier war D63703 7600 CARROLL AVENUE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SABYASACH KAR TAKOMA PARK, M 31. Date filed (Month D Day, Year, State Sauce Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

William Aider	Rive	1- For State Certificate of Death	1492			
Phys	ician	1. Decedent's Name (First, Middle,Last) 2. Date of Death 3.	Time of Death			
Medical Exa		William Aiden Rivera Schaeff April 22, 2010	0640 hrs			
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 7601 Woodmont Avenue 4c. County of Death Montgomery				
Funer Direct		5. Social Security Number 214-79-9921 1 M 2 F 17 Yrs. If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplate 19 Months Days Hours Min. May 25, 1992 Country Number 19 May 25, 1992 Country Number 19 May 25, 1992 Country Number 214-79-9921	Canada			
any .		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10	d. Inside City Limits			
*	Duce.	Maryland Montgomery Silver Spring	Yes 2 X No			
the Mary	lifted at one	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 2310 Peggy Lane 20910 Canada	?			
r death with the Maryland or items 23s or 28s-f sh	other traumatic event, the Medical Examiner must be notified at once. To Re Completed by Ermeral Director					
rs afte ural",	E laine	3 Widowed 4 Divorced in res, give tear or Dates: 15 December 5 Education (Specify only bisheet grade completed). 160 December 10 Page 11 All Specify: 1 del Control Specify: Will Cell Specify: 1 del Control Specify: Will Cell Specify: Will C				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after de Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or	the Medical Exa	Elementary/Secondary (0-12) College (1-4 or 5+) 11 Artist Self-Employ				
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene 77 is marked other then	He We	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Mid				
215 be file ental H	Rent, f	Patricia Rivera Spencer				
D 21 Should and Me	atic e					
and 2 lealth g	fraum	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Tow				
Baltimore, permit. Pages 1 a Department of He Important: If it	other	1 Burial 2 X Cremation 3 Removal from State crematory or other place) April 24 Alexandria,	VA			
altin mit. P partme	ury or	2) Signature of Funeral Service Licensee 2) Signature of Funeral Service Licensee 2) Signature of Funeral Service Licensee 2) Signature of Funeral Home Inc.				
		Kehand Lolling 500 University Blvd. W., Silver Spring				
Physicia		failure. List only one cause on each line.	Approximate Interval Between Onset and Death			
Examin	er	Immediate Cause (Final disease or condition resulting in death) a. Hanging Due to (or as a consequence of):				
		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	nsit Examiner	cause. Enter Underlying Cause (Clisical or Injury that initiate.)				
L3 executed	ransit	events resulting in death) Last Due to (or as a consequence of): d.				
	urial - transit	UNPENDED AMENDED				
Leq A-{ (F) DAMS. O. Box 68760, hat the death certificate by the attending physic.	ched for use as the bu	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown 9 Unknown	Year			
O. E	ched q		cause of death?			
(2, P , P signe	43					
TAwaka 4/22 (of Vital Records ing Physician: The law required After this certificate has been s	Completed	24a. Was an 24b. Were autops	sy findings available pletion of cause of			
Re The	r, page		2 No			
/ital	director, page	examiner? Hospital: 1 Inspired: 2 EB/Outpation: 2 DOA Other Nursing Home 5 Pacidage 6 Other 6	ene			
per Threekr ision of Vital R Attending Physician: Ti death.	uneral	27 Manner of Death 28a Date of Injury 28h Time of Injury 28c Injury at Work? 28d Describe how injury occurred				
ision Attendi	filled in by the fune	1 Natural 5 Pending Pending Investigation Provided Provid	To de Nombre Cito			
	3 V Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural For Town, State) 7601 Woodmont Avenue, Bethesda, M					
27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 1 Suicide 4 Homicide 29s. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 28a. Date of Injury FOUND: 1 Yes 2 No Subject hanged self 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 3 Subject hanged self 28c. Injury at Work? 1 Yes 2 No Subject hanged self 28d. Describe how injury occurred subject hanged self 28d. Describe how injury occurred subject hanged self 28d. Describe how injury occurred subject hanged self 28d. Describe how injury occurred subject hanged self 28d. Describe how injury occurred subject hanged self 28d. Describe how injury occurred subject hanged self 2						
To	Con	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month,				
5		Theodor M. King JR., M. D. O.C.M.E. OCME April 23, 2010				
		30. Name and address of person who completed (plause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201				

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 22, 12:58pm April Richard Scheuerman 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Takoma Park Washington Adventist Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours Months 1 X M 2 □ F 80 washington, 578-36-6842 08/16/1929 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Predical Examinant must be not fifted at 1 ☐ Yes 2 No Director Silver Spring Maryland Montgomery within 72 hours after death with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20903 u.s.A. 1405 Stateside Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 No Korean 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: Conflict Specify: 2 White 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Billing Clerk Plumbing Firm 18. Mother's Name (First, Middle, Maiden Surname) t of Health and Mental Hy 17. Father's Name (First, Middle, Last) Be Thelma Wilkerson William Scheuerman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1405 Stateside Drive, Silver Spring, MD 20903 Kathleen Mayers - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 04/26/2010 Silver Spring, MD Gate of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, ANal 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final √ Physician Decompensated Heart Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Bacteremia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for se a consequence of burial-transit Exami Cardiomyopathy and Due to (or as a consequence of): attending physician for use as the burial P.O. Box 68760. death certificate be Physician/Medical Pneumonia IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No the 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🖾 No Hospital or Attending Physician: '24 hours after death.
Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Hosp within 24 hor To the Fune (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

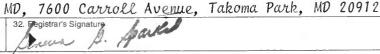
State Registrar

31. Date filed (Month, Day, Year)

APR 2 6 2010

Padma Chirumamilla.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



3+1

D63839

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 Physician/ Month April Year Gretchen C. Sharpe 23, 12:40 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Montgomery Hospice - Casey House Rockville Montgomery Social Security Numbe If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months 1 DM 2 X F Days Hours 388-18-6644 88 September 8, **Director** 1921 Wisconsin Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Silver Spring Montgomery 1 🗆 Yes 2 ื No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 15316 Pine Orchard Drive, Apt. 20906 2E USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Ongin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🔀 No þ within 72 hours after 1 ☐ Yes 2 K No Specify. "natural", Specify: Completed 3 X Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant National Institute of Health Be 17. Father's Name (First, Middle, Last, Should be file and Mental H 18. Mother's Name (First, Middle, Maiden Surname) Robert Connor Bertha Gurtler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, ge 1 and 2 sl it of Health a : If item 27 is Judy Lim-Sharpe / Daughter 805 Loxford Terrace, Silver Spring, MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 🗆 Burial 2 📭 Cremation 3 🗀 Removal from State April 24, 2010 Alexandria, Virginia Metropolitan Crematory 4 Donation 5 Other (Specify) ²² Name and Address of Each Line Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 21. Signature of Fune al Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List and one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Infarction Involving Left Periventricular disease or condition resulting in death) Medical Due to (or as a consequence of): White Matter Extending to Basal Ganglia Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed be det 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform death? 2X No 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospice Facility Other: 1 ☐ Yes 2X No ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural 5 Pending 1 Yes 2 🗌 No ☐ Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical

68760 Box P.O. Records, To the Hospital or Attending Physician: Division of Vital hours after death. uneral Director: Aft ed filled in by the fur 24 hours Funeral completed

Maryland 21215-0036

Baltimore,

10

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

Name and address of person v Bindu Joseph,

son who co

State Registrar Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D60634

29d. Date signed (Month, Day, Year)

April 23, 2010

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 3:10 pm Bernard Simon 20, April 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner #1004 15115 Interlachen Drive. Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 X M 2 □ F 89 052-16-0579 Director New Jersey May 07,1920 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County "naturai", or items 23a or 28a-f show sdical Examiner must be notified at 1 Yes 2 No Directo Maryland Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 15115 Interlachen Drive. 20906 u.s.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No 1941 -If Yes, Give Year or Dates: 1945 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify Specify: þ 3 Widowed 4 Divorced White Completed permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "naturaly injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Philanthropic Elementary/Secondary (0-12) College (1-4or 5+) Public Relations Director Organization 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Max Simon Maru Kell 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Simon - Son 8906 Maxwell Drive, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 Donation 5 ☐ Other (Speoffy) King David Mem. Grdns 04/22/2010 Falls Church, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. MD0709 ₹1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Immediate disease or condition resulting in death) Cardiac Arrhythmia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Line Underlying Cause (Disease or injury Due to (or as a consequence of): sician and burial-transit certificate be executed Exami that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4<u>□</u>Pregnant at time of death 5 ☐ Other (specify) P.O. ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has performed? Yes 2 \(\bar{\Delta}\) No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🔀 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 X Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director... filled in by the 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature 29c. License number and title of certifier 29d. Date signed (Month, Day, Year) April 21, 2010 D20388 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard Goldstein, MD 10401 Old Georgetown Road, #104, Bethesda, Maryland 20815 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

APR 26 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 30 per DVR G903 5/12/10 dk
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3,2010 ear 8:15 P M Edna Lourine Sanders Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u> Montgomery General Hospital</u> Olney Montgomery Social Security Number 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Months Hours Min. (Month, Day, Year Georgia Director 379-34-9052 Usual Residence of Decedent ms 23a or 28a-f shormust be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director X Yes 2 □ No Michigan Detroit Wayne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 48235 19466 Steel Street U.S.A. item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 M Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) U.S.P.S. Director of Finance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Susanna Goodwin Lafayette Wynn permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25110wens Road, Brookeville, Maryland 20833 Linda S. Stewart/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date N Burial 2 ☐ Cremation 3 ☐ Removal from State Elmwood Cemetery 5-11-10 Detroit, Michigan Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P. A nichael 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tipe. Approximate Interval Between Onset and Death Immediate Cause (Final reumonta Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to for serie nonsequence offi if any leading to kinned cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or iinjury After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown disens renul 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe 25. Was case referred to medical examiner?

1 Yes 2 1 10 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Aatural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director: A

completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 [] 3 [] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5/3/200 363999 70 molnme 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ata Motamedi, 18111 Prince Phillip Drive, Suite 101, Olney MD 20832 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009

Dr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lagda Scherer	State of Maryland / Depa 1-For State Registrar amend#5, per FH, QACHD, ms, 4/29/160	artment of <i>rtificate</i> of	Health and M Death	lental Hygien	e 20	10 14933								
Physician Medical Examina	Decedent's Name (First, Middle,Last)	Comparison of Death Comparison of Death												
	4a. Facility Name (if not institution, give street and number) 310 Oxbow Drive	4			1 15, 2010 4c. County of Queen A									
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. I	last birthday)		Under 24Hrs. 8. Dat	te of Birth (MM/DD/YYYY	9. Birthplace (State or								
Director	095-28-0016 UNKNOWN 1 M 2 X F 82	Yrs.	Months Days H	Hours Min. MA	RCH 21, 192	Foreign CCECRMANY								
lny	Usual Residence of Decedent 10a. State 10b. County 10c. City,	, Town or Location	on			10d. Inside City Limits								
vfaryland 28a-f show any 1 at once.	MARYLAND QUEEN ANNE'S ST	(EVENSVI)	LLE			1 Yes 2 X No								
the Maryland a or 28s-f sh	10e. Street and Number			• *	10g. Citizen of Wh									
r death with the Maryland or items 23a or 28a-f sho must be notified at once			Decedent of Hispanic		s or No- 14. Race	STATES - American Indian, Black,								
	1 Never Married 2 Married Armed Forces? 1 Yes 2 No		_			o, etc. WHITE								
urs afte	or Dates:	16a. Decedent	s Usual Occupation (C	Give kind of work done	e 16b. Kind of Bu									
136 thin 72 ho e. than "na than "na edical Ex-	Elementary/Secondary (0-12) College (1-4 or 5+)		•	NOT use retired)	BANKI	NC								
21215-0036 uld be filed within 72 hou Mental Hygiene. marked other than "natt event, the Medical Ear	17. Father's Name (First, Middle, Last)	DANN		other's Name (First, M	Middle, Maiden Surname)									
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	DIETER T. SCHERER/SON	ARTIN PAJONK ARTIN PAJONK ANNA V Tann's Name/Relationship (Type, Print) TER T. SCHERER/SON Od of Disposition Tial 2 X Cremation 3 Removal from State Other Specify: Ten of Fineral Service Licenses Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of e. List only one cause on each line.												
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Examiner		Name and Address of Facility FELLOWS, HELFENBEIN (106 SHAMROCK ROAD, CI) I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or response. List only one cause on each line. the Cause (Final disease a. Blunt Force Head Injuries												
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Box 6876 e death certificate the attending phy ed for use as the by	Ves 2 ✓ No 9 Unknown Lo Utelescope	eath 5 Oth	er (Specify)		_									
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Division of Vital Records, spital or Attending Physician: The law require hours after death retail Director: After this certificate has been similed in by the funeral director, page 2 should be certified in by the funeral director. To Re Commissional Certification: To Re Commissional	3 Suicide 6 Could not be determined (Specify) Single Fam		, factory, office building	or T	ation (Street and Numbe Fown, State) bow Drive, Stevensvil	er or Rural Route Number, City								
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funneral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the beautified Certification: To Be Completely Hospital Direction and Completely Modernal Directions and Completely Modernal Directions and Completely Modernal Certification:		-												
To To Soil	and manner stated. 29b. Signature and title of certifier		29c. License num	nber		ed (Month, Day, Year)								
OUR	30. Name and address of person who completed cause of death (Item	23a)	O.C.M.E.		April 16, 20	10								
1	Laron Locke MD. Assistant Medical Examiner		Street, Baltimore	, MD 21201										
Stat	31. Date filed (Moath Pay, 19an) 2010 32 Registrar's Signatu	e ban	4											

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 2^{Day} Otto Charles Schauble, Jr. 5:30 P M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 4C Nicholson Drive Pasadena Social Security Number If Under 1 Year If Under 24 Hrs. Date of B. (Month, Day, Ye 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Y^{ear)}1<u>936</u> 1 🛛 M 2 🗆 F Months Days Hours Director Sep. 086-28-6687 ŊJ 73 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Directo MD Anne Arundel Pasadena 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21122 USA 4C Nicholson Drive 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ٥ Completed by 1 Never Married 2 X Married Yes 2 No Yes, Give 771 Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: n res, Give Year or Dates. Vietnam Specify: should be filed within 72 hours aft and Mental Hygiene. 'is marked other than "natural", 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Navy Trumpet Player Military Be unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Otto Charles Schauble, Sr. Miriam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6213 Redwing Court Bethesda, MD 20817 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Rachel A. Loock/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of April 24, 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2010 Baltimore, MD 22. Name and Address of Facility Barranco & Sons, P.A. 495 Ritchie Hwy. Severna Park Funeral Home Severna Park, MD 21146 14 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, OVONAY disease or condition Medical resulting in death) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 🗌 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MelliTu Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 performed certificate 2 No 1 Yes Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ nesidence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29c. License number

8

State Registrar 31. Date filed (Month, Day, Year)

Detense

32. Registrar's Signatur

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Year Sarkassian Setrak 2010 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City. Town, or Location of Death 4c. County of Death HICAMICA REGIONAL SMISHING TENINSULA If Unde 1 Year | If Under: 7. Age (In yrs, last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 X M 2 🗆 F Months Days Hours Min **Director** Svria 900-32-6521 Mav Usual Residence of Decedent 10a. State with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director notified 28a-f MD Wicomico Salisbury 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? ms 23a or must be r Funeral 100 E. Carroll St. 21801 Syria permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked Annamed any injury or others. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces Black, White, etc ģ 1 Never Married 2 Married 2 **X** No Yes If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: white Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bumper Auto Repair Shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 <u>Toros Sarkassian</u> Maroum Pehlivanian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nephew Sarkis Sarkassian 33195 Sherwood Forest, Sterling Heights, MT 48310 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗆 Burial 2 🗆 Cremation 3 🙀 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 5/5/10 Detroit, MI 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Short Funeral Services Devid Federal St., P.O. por 2. M P.O. Box 233, Milton 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ASCV Physician/ disease or condition Medical resulting in death) Due to (or as a onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate 2 No 1 Tyes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 Tes 2 4 No Other: ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending work 2 No 24 hours after death Funeral Director: / Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed within 2 3 Certifying Nurse Practioner: To the best of my knowledge, de eath occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

State of Maryland / Department of Health and Mental Hygiene 2 1 For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9:10P M MAY 4,20 0 Physician/ JUNE SMITH STARK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES LA PLATA ABBEY MANOR If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday **Funeral** Months Days Hours Min. 1 M 2 F 91 6 4 3 0 Day 1 9 1 8 SOUTH DAKOTA 505-12-1364 Director Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Examiner must be notified at Director LA PLATA CHARLES MD. 1 X Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a U.S.A. Funeral 20646 121 MORRIS DRIVE items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. 1 and 2 should be filed within 72 hours after d of Health and Mental Hygiene. item 27 is marked other than "natural", or i other traumatic event, the Medical Examin þ 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Maryland 21215-0036 Specify:WHITE 1 ☐ Yes 2X No Specify. 3X Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) SOUTH DAKOTA Elementary/Seconday (0-12) College (1-4 or 5+) SECRETARY CONGRESSMAN 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARY EBSEN FRED SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20601 WALDORF, MD. 4457 JORDEN LANE ROBERT D.STARK, JR.-SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of I-Important: If ite any injury or ot 1 Burial 2 XCremation 3 Removal from State METROPOLITAN CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 5-6-2010 ALEX., VA. Signature of Fugural Service Licenses 22. Name and Address of Facility MQQ479 RAYMOND FUNERAL SERVI enter the mode of dying, such as cardiac or respiratory 23a. Part 1. Enter the disease, or complications that caused the de-Approximate shock, or heart failure. List only one we on each line In erval Between onset and Death Immediate Cause (Final ONGERTS enysician. disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** JERCY I Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death signed by the a Id be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 🗌 Yes 2 🗎 No 3 Probably 4 Unknown Division of Vital Records, Completed should peen s Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page Yes 2 1 Yes 2 No ospital or Attending Physician: hours after death. 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 2 1 No (Specify) ASSUSTED 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work?
1 Yes 2 No 1 Natural 2 Accident 5 Pending FACIR Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, completed cause of death (Item 23a) (Type, Print 2 31. Date filed (Month, Day, Yes 32. Registr State 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Hame (First Middle, Last) Yeer 8:40 M **Physician** 2010 -/Medical (If not institution, give street, and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours Min 1 M 2 X Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 PNo by Funeral Director 10f. Zip Code 10g. Citizen of What Country? Items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Forces? Black, White, etc. 1 Never Married 2 Married 1 □Yes Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic. Elementary/Secondary (0-12) College (1-4or 5+) TEACHER 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Num. er or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 ☑ Surial 2 ☐ Cremation 3 ☐ Removal from State • 4 □ Donation 5 □ Other (Specify) 21. nature of uneral Service I 22. Name and Address of Facility Scott Funeral Home 115 E Brookland Park Blvd Richmond Va 23222 Approximate Interval Between Onset and Death er the disease, or complications that caused the or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, a heart ailu Immediate Lause (Final disease of condition resulting in death) Faclure **Physician** Weeks /Medical Due to (or as a consequence of) **Examiner** failure on dialysis Year KIDNEY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Box 68760. or Attending Physician: The law requires that the death certificate be Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ Hypertension 2 12 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an 2 No this certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours after To the Funeral Dire Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and que to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Sindhera DOO61614. May 2nd, 2010

State Registrar

DHMH 17 Rev 1/2001

Barks

6 Post Office Rd Waldorf Md 20603

SUITE 101

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Sindhwani MD

Ravi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician/ Month FRED THAETER PRTI 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth
(Month, Day, Year)
June 5, 1920 9. Birthplace (State or Foreign **Funeral** 1 ₹ M 2 □ F Canada Director 89 277-12-3327 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 21704 5955 Quince Orchard Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces' þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates. WWII White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Maryland School Elementary/Seconday (0-12) College (1-4 or 5+) for the Deaf Stationary Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Thaeter Elsie Fuller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Knoxville Road, Knoxville, Maryland 21758 Stacy Myers/ Daughter permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Stauffer Crematory Inc.4/29/2010 Frederick, Maryland. 21. Signature unera 22. Name and Address of Facility
Stauffer Funeral Homes P. A.
1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Cardiopulmonary Arrest Medical Due to (or as a consequence of): Examiner COPD Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the busing the standard of the busing the business of the business that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death 5 Other (specify) 2 No 1 L Yes 2 L g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined Medical 29a. Certifier Lertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ricova MDD65443 4/25/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 W 7th St Elena Iarikova 21701 10 HUA Frederick

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year Sheila T. Talcott \underline{a}^{M} <u>Apri</u> 2010 4:15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sunrise Assisted Living <u>Columbia</u> Howard Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. 06/25/1935 **Director** 064-32-8247 74 Usual Residence of Decedent 28a-f shov 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo MD Howard 1 Yes 2 XNo West Friendship 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2673 Wellworth Way 21794 United States death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc. "natural", or ģ 1 Never Married 2 Married 1 ☐ Yes 2 🛭 No If Yes, Give within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 ☐ Mo Specify: Completed 3 Widowed 4 N Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. tem 27 is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Executive Secretary Utilities 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James G. Tremaine Phyllis Bickford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2673 Wellworth Way James T. Talcott - son Page 1 and 2 West Friendship, MD Baltimore, Important: If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 and Department of I Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Spegity) Putnam Cemetery 05/07/2010 Greenwich, CT 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. . Sig y tur, of Funeral Service License M00845 4112 Old Columbia Pike Ellicott City, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Spinal Stenosis Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Parkinson's Disease 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform Yes 2 🔀 No 2 X No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 XNo Hospital: Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) Assisted Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Living Natural Accident 5 Pending injury 1 Tes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D56531 April 28, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harry Li, M.D. 8600 Snowden River Pkwy. #301 Columbia, MD 21045 State 32. Agistrar's Signature

Registrar

			For State	State of Marylan		artment <i>rtificate</i>			Mental H		2010	1494
	X		Registrar 1. Decedent's Name (First, Middle, Las	st)		imoure			2. Date of I			3. Time of Death
	Physici Medi		R. Thomas Thayer	Jr.					Month 04/26	/2010		4:45 A M
	Examir		4a. Facility Name (If not institution, give			4b. City, T	own, or	Location of Dea			County of Deat	
			1523 Oakland Sang	Run Road		0akla	nd ,			Ga	rrett	
-	Funeral	1	5. Social Security Number 6. S	M 2□ E	a <i>st birthday)</i> Yrs.	If Under Months	Days	If Under 24 Hrs Hours Min	. (Month, I	Day, Year)	Co	hplace (State or Foreigi untry)
	Director		220-18-3030 Usual Residence of Decedent	84			-		04/18	/1926	MD	
	yland now at		10a. State 10b. County	10c. City	, Town or Lo	ocation						10d. Inside City Limits
	Mar a-f st iified	ctor	MD Garrett	0a	kland							1 □ Yes 2√∑ No
	e not	Funeral Director	10e. Street and Number			10f. Zip	Code			10g. Citi	zen of What Co	untry?
	ath w	<u>ra</u>	1523 Oakland Sang			215					ed Stat	
	er de items	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces?	S. 13.	If Yes, spec	ent of His ify Cuba	spanic Origin? (n, Mexican, Pue	Specify Yes or I rto Rican, etc.)	No-	 Race - Ame Black, White 	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	3 Widowed 4 □ Divorced	1		1 ☐ Yes 2	∏ No	Specify:			Specify:Whi	te
15-0	"natur	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Dece (Give	dent's Usua kind of won	Occupa	ation luring most of wo	orking	16b. Ki	nd of Business/	Industry
121	filed within Hygiene. ther than "	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)						Rea	1 Estat	A
d 2	filed withi Hygiene. other than ent, the M	Be Co	17. Father's Name (First, Middle, Last)		Vec	II ESL	are	Develop 18. Mother's Na	me (First, Midd			
Maryland	2 should be f and Mental b Is marked of aumatic ever	To B	Ralph Thayer					Helen H	elbig			
ary	should be mail	-	19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address				nber, City o	r Town, State, 2	Iip Code)
	f and 2 Health a tem 27 Is		Tommy Thayer, Son		351 N	. Bra	dley	Lane 0	akland,	MD 2	1550	
ore	0 0 + F		20a. Method of Disposition 1 ☐ Burial 2√☐ Cremation 3 ☐	Removal from State	lace of Dispo emetery, cre	osition <i>(Nam</i> matory or ot	e of her plac	e)	Date	20c. Lo	ocation - City or	Town, State
Ë	Pages Iment of I tant: If ite jury or o		4 ☐ Donation ¹ 5 ☐ Other (Specif	y) Cu	mber1a	and Cr	emat	ory 04	/30/201	Cum	berland	, MD
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licer	Sweiter	21	. N. S	econ	d Stree	t Oakla	nd, M		ral Home P.
ř.			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.	. Do not en	ter the mode	of dyin	g, such as cardia	ac or respiratory	arrest,		Approximate Interval Between
7	Physician		Immediate Cause (Final disease or condition	CONSESTING	hem	of ta	ilu	Re				Onset and Death
	/Medical Examiner	Н	resulting in death)	a. CONSESTING Due to for as a consequence.	ence of):	1.						41
k	LAGITITICI	7	Sequentially list conditions,	b. Oronony a	m / en	1 di.	109	se				months
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	hunested	الكما							URS
	execunate and al-tra	Exar	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):							(7)
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	rtifical ng ph as th	Nedi	IF FEMALE:									
Вох	ath ce ttendi or use	sician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta	death 3	⊒Ectopic pre					23d. Date of del Month	livery Day Year
	the a	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	eath 5	Other (sp	ecify)			-		
P.0	ires that the de signed by the I be detached	Phys	Part II. Other significant conditions	contributing to death but not resi	ulting in the u	ınderlying ca	use give	en in Part I.	23e. Di	d tobacco u	use contribute to	the cause of death?
ds	uires I sign Id be	d by	COPD						13	Yes 2	□ No 3□ Pi	robably 4 Unknow
or Vital Records,	w requir been s	Completed							24a. W	as an	24b. Were au	utopsy findings available
Re	The lav	dwo						· · · · · · · · · · · · · · · · · · ·	pe	rformed?	prior to death?	completion of cause of
ita		Be	25. Was case referred to medical					26. Place of De	1□ Yes		1 10163	2 140
r <	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3□ DO	A Othe	er: 4 ☐ Nursing	Home 5	esidence	6 □Other (Spe	cify)
	ding Phy h. After thi funeral o		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 2	Bc. Injury Work	y at </td <td>28d. Describ</td> <td>e how inju</td> <td>ry occurred</td> <td></td>	28d. Describ	e how inju	ry occurred	
sio	r Attending er death. rector: After by the fune	catio	2 Accident investigation 3 Suicide 6 Could not b			М		Yes 2 □ No				
Division	후 후 후 c	Certification:	4 Homicide determined			reet, ractory	, опісе			n (Street an Town, State		ural Route Number,
	o the Hospital or Attenvihin 24 hours after death of the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Pt	nysician: To the best of my kno	wiedge, dea	th occurred	at the tin	ne, date and pla	ce, and due to t	he cause(s	and manner as	s stated.
	e Hos 24 h e Fun letely	Medical		miner: On the basis of examina and manner stated.								
	o th o th	Me	29b. Signature and title of certifier	1111		290	License	e number		29d. Da	te signed (Mont	th, Day, Year)

State Registrar

15

30. Name and address of person the completed cause of death (Item 23a) (Type, Print)

DONALD R KICKERMS 1027 MEMBRIALDRIA OAKLAND MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature

D30035

12010

			1 - State Registrar			Ce	rtificate	of D	eath			Reg. No.	2010		94:
			1. Decedent's Name (First, Middle,	Last)						2.	Date of Do		Year	3. Time of	Death
	Physici /Medi		Mary R Teets)4/27	Day 2010 / 20		9:35	Рм
er.	Examir		4a. Facility Name (If not institution,	give street and num	ber)		4b. City, To	wn, or L	ocation of		77,51		County of Deat		
أعبر			Garrett County	Memorial I	Hospita	1	0akla	and				Ga	rrett		
	Funeral	-		6. Sex 7	Age (In yrs. I		If Under 1	Year Davs	If Under 2	4 Hrs. 8. Min.	Date of Bi (Month, D	rth		hplace (State o	r Foreign
	Director		236-32-6523	1 □ M 2 🟋 F	84	Yrs.	Months	Jays	Hours		0/21/		WV	utury)	
	P.		Usual Residence of Decedent												
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	e Ma	ct	MD Garr	ett	0ak	land								1 ☐ Yes	2 X No
	or 28	ä	10e. Street and Number				10f. Zip C	ode				10g. Citi	zen of What Co	untry?	
	23a	<u>a</u>	826 G. Swauger	Road			21550)				Unit	ed Stat	es	
	r dea	Funeral Director	11. Marital Status	12. Was Deced Armed Ford	ent Ever in U.Ses?	5. 13.	Was Deceder If Yes, specifi	nt of His	panic Origi . Mexican.	in? (Specif	y Yes or N an. etc.)	0-	14. Race - Ame Black, White	rican Indian,	
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and	ould be fi Mental H arked ot atic ever	Be	17. Father's Name (First, Middle, L	ast)							irsi, ivilgigie	e, iviaiden	Surname)		
ž	should and Mer s marke umatic	은	Ross Trickett						Ignes						
Maryland	2 sho and Is ma rauma		19a. Informant's Name/Relationsh			19b. Maili	ng Address (8	Street ar	nd Number	r or Rural R	loute Numi	ber, City o	r Town, State, 2	Zip Code)	
	s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exprehent must be notified at		Linda Wilson, D	aughter	1001.0		3. Swat							- 0	
0	ges 1 If of F or ot		20a. Method of Disposition 11☑ Burial 2 ☐ Cremation	B Removal from Si	tate 206. P	ace of Dispo emetery, cre	sition (Name matory or othe	ot er place,	, 5	Date /1/20			cation - City or		
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Baltimore,	permit. Pages: Department of I Important: If ite any injury or of		21. Signature of Funeral Service L	opensee		2	2. Name and	Address	of Facility	David	A. B	urdo	ck Fune	ral Hom	e P.A
	□□ = # 0		Hard AY	Durdock		2	1 N. S	ecor	nd St	reet	0akla	nd, 1	MD 2155)	
			23a. Par 1. Enter the disease, or c	omplications that can nly one cause on ea	used the death ch line.	Do not en	ter the mode	of dying	, such as c	cardiac or re	espiratory	arrest,		Approximate Interval Bet	ween
J.	Physician		Immediate Cause (Final disease or condition			ch	vani	pen	and a	61	12			Onset and I リモン	
	/Medical		resulting in death)	Due to (o	r as a consequ	ence of):		10		1.70					_
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Ö,	e exe ian a uriai-		resulting in death) Last	Due to (o	r as a consequ	ience of):									
68760,	that the death certificate be executed ted by the attending physician and detached for use as the burial-transit	Medical	`	đ											
39 ×	ing p	Mec	IF FEMALE:												
Bô	ath ce ttend		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	ome of pregna rth 2 ☐ Fetal		☐ Ectopic pre	gnancy				2	23d. Date of del		/aar
	he a	sici	1 □Yes 2 ☑No	4 ☐ Pregna	ant at time of d	eath 5	Other (spec	ify)					Month	Day	Year
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Division of Vital Records,	The cate ha	Completed									perf 1 ☐ Yes	ormed?	death?	2 🗆 No	2000 0
ita	Iclan: Th certificate ector, pag	Be C	25. Was case referred to medical						26. Place of	of Death (C					
>	ding Physician: 1. After this certific funeral director,	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ In	patient 2	ER/Outpatie	nt 3 🗆 DOA	Other	4 Nur	sing Home	5 ☐ Res	idence 6	6 □Other (Spe	cify)	
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Vis	Afte ar dea ecto by th	E C	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	t be 28e. Place o	f Injury - At ho g, etc. (Specif)	me, farm, sti	eet, factory, c	ffice		28f.	Location	(Street an	d Number or Ri	ıral Route Num	ber,
Ö	al or s afte	Certification:	4 Hornicide	Dallali	g, etc. (opeon)	,					City of To	wn, State,	,		
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	al (29a. Certifier Certifying	Physician: To the base	est of my know	wledge, deat	h occurred at	the time	e, date and	d place, and	d due to th	e cause(s)	and manner a	s stated.	
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			1	ollm				1)	15 3	333		4/	28/12	,	
		12	30. Name and address of erson w	ho completed cause	of death (Item	23a) (Type,	Print)						-		
		10	T.G. Johnson 3	ll N. Four	th Str	eet Oa	kland,	MD	2155	0					
	Sta	_	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signat										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4/23/2010 George Dorsey Taylor .1:15 AM ^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Worcester If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 **X** M 2 □ F Months Min. 80 /971930 Director Yrs 215-24-9644 MDUsual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Worcester Berlin 1 🗌 Yes 2 🎦 No 10e. Street and Numbe 10f. Zip Code 109. Citizen of What Country? Funeral 306 South Ocean Dr. 21842 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces? 1 X Yes 2 □ No þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes Give white Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Rate Clerk Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Taylor Magdeline (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Taylor (wife) 306 South Ocean Dr. Ocean City, MD 21842 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
Burial 2 Cremation 3 Removal from State 4/27/2010 Cape Henlopen Crem. 4 Donation 5 Other (Specify) Frankford, DE Signature of Funeral Service 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 and . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line, ediate Cause (Final Approximate Interval Between Immediate Cause (Final tue to (or as a consequence of): on and wedle Inset yd De h Physician/ disease or condition resulting in death) Medical Examiner Secusaritelly liet exactitions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ None To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide work? 1 ☐ Yes 2 ☐ No injury 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lot 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year 12:50 am Nellie Twe Apri. 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince George's Doctor's Community Hospital Lanham If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Min. **Director** 84 062-32-3600 1925 iberia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits r 28a-f s notified 1 Yes 2 X No Prince George's Maryland Largo 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Examiner must be Funeral 23a U.S.A. 20774 600 Largo Road items death \ Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or þ 1 X Never Married 2 Married hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates Black Specify Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event, the Me once. life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Claims Adjustor Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1509 Athens Road, Wilmington, Delaware 19803 Arthur Padmore - Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 🖔 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory: 04/28/2010 Brentwood, Maryland 22. Name and Address of Facility Hines-Rinald Funeral Home, Inc. of Funeral Service Licenses |11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Year Month Day signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 2 **N**No Yes within 24 hours after death.

Vo the Funeral Director: After this certific completed filled in by the funeral director, it To the Hospital or Attending Physician: 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 - ER/Outpatient 3 - DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of certifier person who completed cause of death (Item 23a) (Type, Print) VERWA 7925 Greenway Center Drive

Registrar

State

2. Registrar's Sigi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ James Clifford Month Thomas 5:30 a M 20, April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Fairland Adventist Nursing & Rehab. Montgomery Silver Spring 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours Min. De C. Pay, Yar 29 West^{ry)}Virginia 220-26-7596 80 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location hours after death with the Maryland Director 10d, Inside City Limits 1 🗌 Yes 2 😾 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Examiner must be 23a Funeral 4236 Isbell Street 20906 USA items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Specify: White Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 th and Mental Hygien

7 is marked other the Produce Manager Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked a any injury or other traumatic eve once. ೭ Clayton E. Thomas Katharine Irene Savage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah K. Dyer/Guardian 4236 Isbell Street, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State April 22 2010 Metropolitan Crematory Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Collins Funeral Home itv Blvd. W., Silver Francis J. Home Inc 500 University Blvd. MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death
1 year Immediate Cause (Final Physician/ Alzheimer's Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence offs Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕇 Unknown To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No æ 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 🔀 No မ 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) within 24 hours Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D28656 April 20, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravi Passi, MD 15245 Shady Grove Road, #130, Rockville, MD 20850

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month)

26 Day, Yea

2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Funeral Director		259-22-7330 Usual Residence of Decedent	4 🗆 14 0 🕅 🗆	86	Yrs. Mont		Hours Min	Aug.	16, .	1923	Country) Georgia	
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and 2 shorelth and h		19a. Informant's Name/Relation Marjorie D. Ti					nd Number or R 1 Drive,					7A 2220
permit. Pages 1 and 2 should be filed within Depertment of Heelth and Mental Hygiene. Important: If Item 27 is marked other than any injury or other freumatic event, the M. Once.		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (e cemete	of Disposition (a ery, crematory o oolitan	or other place Crema	tory	Date April 2: 2010	Ale	ocation - City exandr i	.a, Vir	ginia
permit. Depert Import any inj		21. Signature of Funeral Service	Averale		22. Name Frai 500 U	and Addres ncis J Jniver	s of Facility • Collir sity Bly	s Fune	ral H Silv	Home In Ver Spr	c. ing, M	ID 2090
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ificate be executed XX physicien and BX sthe burial-transit of	edicai Examiner	Sequentially list conditions, any, bearing to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. Cua to (or t	s Mirabl	ot):							
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Physician: this certifice ral director, p	To Be	25. Was case referred to medic examiner? 1 Tyes 2 No	Hospital: 1 ☐ Inpa	tient 2 ER/O		DOA Othe	4 1 Nursing i	lome 5□Re	sidence		Specify)	
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₽ # # = =		4 ☐ Homicide deter	mined 259. Place of i	njury - At home, f etc. <i>(Specify)</i>				City or 1	own, Sta			Number,
To the Hospitel within 24 hours a To the Funeral completely filled	Medical	29a. Certifier XX Certify (Check only 2 Medica	ing Physician: To the best I Exeminer: On the basis and manner	of examination a	je, death occuri nd/or investigat	ed at the tim ion, in my op	e, date and place inion, death occ	e, and due to thuring at the time	e cause(e, date ar	s) and manner nd place, and	r as stated. due to the cat	120(2)
Mithi To the comp	Σ	29b. Signature and title of certifi	Miles	20		29c. License D26				ate signed (M		ar)
		30. Name and address of person Lester Miles,		death (Item 23a) Varnum S		NE, W	ashingto	on, DC	20017	7		
Sta Registi		31. Date fifed (Month, Day, Year	2010 32. Regis	trar's Signature	barred							

DHMH 17 Rev 1/2001

The law requires that the death certificate be executed attending physician Hospital or Attending Physician:

for

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

"natural", or items 23a or 28a-f show dical Examiner must be notified at

se 1 and 2 should be filed within 72 ho of Health and Mental Hygiene. I flem 27 is marked other than "natur other traumatic event, the Medical

permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause

29b. Signature and title of certifier

29a. Certifier

32. Registrar's Signature

of death (Item 23a) (Type, Print) elli

1 / Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month April Physician/ 20°10 08:29 AM William H. Taylor, Sr Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cecil 60 Razor Strap Road North East 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Nov 9 1 g. Birthplace (State or Foreign Hawmey) de Grace Mary Land 7. Age (In vrs. last birthday) **Funeral** Min. 1 🕱 M 2 🗆 F Hours Director 216-12-6542 1924 85 Usual Residence of Decedent show 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Cecil North East 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21901 60 Razor Strap Road United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 X Yes 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Divorced 4 Divorced Year or Dates.1943-46 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) <u>Chief of Weapons Processing</u> Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Marie Mitchell William A. Taylor permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumati 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 60 Razor Strap Road, North East, Maryland 21901 Pauline Wherry Taylor / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Harford Memorial Gardens Aprilo29, Aberdeen, Maryland Crouch Funeral Home 22. Name and Address of Facility 6 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician years disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause Disease or linjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Yes 2 No 1 Yes 2 9 Unknown g Unknown sate has been signed by a page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Mellitus 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy certificate l To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗹 No Other: 4 \(\sum \) Nursing Home 5 \(\vec{\pi}\) Residence 6 \(\sum \) Other (Specify) 은 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work? Natural 2 Accident
3 Suicide
4 Homicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. D0023322 4/26/2010 High ST, Elbton MD21921. Sachdev.S. MD

12+IVA State

Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

\$\int S FACHDEV MD 126 A E

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 24, Day 2010 Year Mae Vetter 5:30 a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death 3118 Gracefield Road, Silver Spring Montgomery 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Hours Min. Nov. 12 Year) 1920 TTTinois Director 338-12-9181 89 Usual Residence of Decedent show 10b. County should be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 3118 Gracefield Road, CC405 20904 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: 3 Widowed 4 ☐ Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Henry Ruth Emma Elizabeth Storch off. Page 1 and 2 shou...

"vt of Health and Me
"vt of Sing 27 is mr
"vill" 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12913 Byefield Road, Highland, MD 20777 Kathleen S. Johnson/Daughter permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Arlington National
Cemetery 1 🗓 Burial 2 🗌 Cremation 3 🗌 Removal from State May 010' 4 Donation 5 Other (Specify) Arlington, Virginia Signature of Funeral Service Licensee Prancis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph, sician/ Alzheimer's Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4x Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? After this certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 **X**No မှ 1 Inpatient 2 I ER/Outpatient 3 I DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred XX Natural injury 5 Pending 2 Accident 3 Suicide Investigation within 24 hours after death

To the Funeral Director: completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number ٩ 29d. Date signed (Month, Day, Year)

State Registrar

10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Rachelle Alexion, MD

APR 27 2010

D44156

3110 Gracefield Road, Silver Spring, MD 20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Marvland / Department of Health and Mental Hygiene

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Physici	an/	Registrar 1. Decedent's Name (First, Middle, L	ast)		tineate or	Death		2. Date of Dea	eg. No.	3. Tir	The of Death
edical Exam		•	•					Month May 4, 20	Day Yea	.	330 hrs
		4a. Facility Name (if not institution,			41	c. City, Town,	or Location of De		4c. County of	f Death	
		Interstate 68 at Mile Mai	rker 52			Flintstone			Allegany		
Funeral		Social Security Number 6.	Sex 7. Age	(In yrs, I	ast birthday)	If Under 1 Y			th (MM/DD/YYYY		e (State or
Director			<u></u>		21 Yrs.	Months D	ays Hours	Sept.	8,1988	Foreign Country)	PA.
any		Usual Residence of Decedent 10a, State 10b, County		10c. City,	Town or Locatio	n				10d.	Inside City Limits
* .		PA. Fayet	te	Fa	yette (rity				1 🛚	Yes 2 No
Maryland 28a-f show 1 at once.	cto	10e. Street and Number				10f. Zip Code	-	1	0g. Citizen of Wh	at Country?	
h the Ma 3a or 24	Director	100 Daughtert	y Lane			15438	2		TT C 7		
with t		11. Marital Status	12. Was Decedent I	ver in U		Decedent of	Hispanic Origin?	(Specify Yes or No		- American Ind	dian, Black,
leath r iten	Funeral	1 Never Married 2 Marri	ed Armed Forces?	X No	If Yes	s, specify Cub	oan, Mexican, Pu	erto Rican, etc.)	White	, etc.	
after o	by F		ed If Yes, Give Year or Dates:		1 🗆 🕆	Yes 2 <mark>X</mark> X Ι	No specify:		Specify:	White	<u>غ</u>
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5-0036 led within 72 hou Hygiene. other than "nat	Completed	10 17. Father's Name (First, Middle, La	est)		Unen	nploye	18 Mother's Na	ame (First, Middle, I	Maiden Surname)		
21215-0036 Mult be filed within 72 hours after death with the Maryland Mental Hygiens mental and marked other than "natural", or items 23a or 28a-f she event, the Medical Examiner must be notified at once	Bec	Edward Philip	•					ly Clar	,		
T - 0 a >	To E	19a. Informant's Name/Relationship			19b. Mailing	Address (Str		or Rural Route Nun		ı, State, Zip C	ode)
timore, MD 21. Pages 1 and 2 should tment of Health and Mertant: If iten 27 is many or other traumatic ev	13	Shelly Veltre	/Mother		1100 E	aught	erty L	ane Fay	ette Ci	ty, PA	1.15438
	1	20a. Method of Disposition 1 X Burial 2 Cremation	2 Demoval from Sto		Place of Dispositi crematory or othe		cemetery,	Date	20c. Location -	City or Town,	State
MOFE Pages 1 nent of H ant: If i		4 Donation 5 Other Spec		-	-		emeter	y5-10-10	Rostr	aver	Twp., PA
Baltimore, permit. Pages 1 at Department of Her Important: If ite injury or other tr	1	21. Signature of Funeral Service Lice				me and Addre	see of Eacility	arzullo			
@ 89 8 3	5. 7	michael P. mary	ullo				<u>ord Ro</u>	<u>ad,Balt:</u>	<u>imore.M</u>	laryla	<u>ind21214</u>
Physician		23a. Part I. Enter the disease, or con failure. List only one cause on		ne death.	. Do not enter the	mode of dyir	ng, such as cardia	ac or respiratory arr	est, shock, or hea		roximate Interval ween Onset and
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rted d ansit	Ä	events resulting in death) Last	d.	querice o	1).						
ords, P.O. Box 68760, w requires that the death certificate be executed is been signed by the attending physician and should be detached for use as the burial - transit	lical	UNPENDED	AMENDED								
60, cate be	Mec	IF FEMALE:	23c. If yes, outcom	e of preg	nancy				23d. Date of	delivery	
687 ertific ding	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Pregnant at t	me of de	ath -		Ectopic pre	gnancy	Month	Day	Year
Box 687 death certific the attending p	Physician/	1 Yes 2 No 9 Unkno		me or de	ath 5 Othe	er (Specify)					
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of Vita ing Physicia After this cer uneral direct		27. Manner of Death	28a. Date of Injur (Month, Day, Ye FOUND:	/ ar)	28b. Time of Inju FOUND:	ury 28c. in	jury at Work?		now injury occurre		
	atio	1 Natural 5 Pending 2 ✓ Accident Investig	May 4, 2010		0812 hrs	_ 1_	Yes 2 ✔ No				
Division of Vital Records, saler Attending Physician: The law requiring a for a forter dearth. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could no	ot be		ome, farm, street,	factory, office	e building, etc.	or Town, S	Street and Number tate)		
ospita hours uneral		4 Homicide	(Specify little		dth		data and alana	1	at Mîle Marker 5		, MD
Division of 'To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Medical	(Check only	ician: To the best of my ner:On the basis of exam								e(s)
To Wit	Mec	29b. Signature and title of certifier	and manner stated.	10.0	W)	29c. Lice	nse number		29d. Date signe	d (Month, Da	y, Year)
/		July the	bleek	170		0.0	C.M.E.		May 5, 2010)	
		30. Name and address of person wh	o completed cause of de	ath (Item	23a)				<u> </u>		
			Assistant Medical			nn Street,	Baltimore, M	ID 21201			
S ⁱ Regis	tate trar	W 1 . 1 . 2	32, Registrar	s Signatu	T. Bart	20					
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Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 4/24/20^{Day}0 Dorothy Walls Margaret 13:45pM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Clinton <u>Southern Maryland Hospital</u> Prince George If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2🏝 Months 1 1 / 22 1916 Maryland **Director** 215-36-3576 93 Usual Residence of Decedent 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits 1 X Yes 2 No Maryland Charles Brandywine ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 15800 Woodville Road 20613 USA items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give 0 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", Specify: 3 Widowed 4 Divorced Completed Year or Dates Black the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clarence Lvles Mary M. Reeves 19a. Informant's Name/Relationship (Type, Print)

Jamie L. Walls/granddaughter
Phyllis Henry/Daughter 5822 North Poteat Court, California, tate MDC 20619 00_12thst_S.E. Washington DC 2003 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Maryland Veterans 4 Donation 5 Other (Specify) 5/5/10 Cheltenham Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Therese mu 1589 Adams Funeral Home Pa, Aquasco MD 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Due to (or as a consequence of): Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant a
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 1 ☐ Yes 21 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed this certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Yes Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral Date of injury (Month, Day, Year) 27. Manner of De 28a 28b. Time of Certificate: 28c. Injury at After t 28d. Describe how injury occurred Natural injury work? 5 Pending ☐ Accident ☐ Suicide 2 No Investigation s after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 100 e and address of person who completed cause of death (Item 23a) (Type, Print) 2005 31. Date filed (Month, Day, Year) APR 29 2010 Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month / 20/U 0035M WEST -AN Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death Examiner 4b. City, Town, or Location of Death ANNE ARUNDEL HARWOOD MANDARIN HOSPICE HOUSE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Days 1 M 2 F Hours AUGUST 14, 1949 NEW JERSEY 60 219-54-6492 Director Yrs. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director FORT WASHINGTON 1X Yes 2 No MARYLAND PRINCE GEORGES ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 23a Funeral 20744 UNITED STATES 12220 OLD FORT ROAD items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Armed Forces? Black, White, etc. Hygiene. other than "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 X Divorced Specify: BLACK Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12)
12TH GRADE Coilege (1-4 or 5+) METRO BUS OPERATOR TRANSPORTATION and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ CELESTINE PRISCILLA SHORTER WEST CLYDE FRANCIS WEST. SR. permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any Injury or other traumatic once. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TIMOTHY WEST / BROTHER 14860 AUGUSTA CLASSIC PLACE, HUCHESVILLE, MARYLAND 20637 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State WESTPHALIA CHURCH CEMETERY MAY 4, 2010 UPPER MARLBORO, MARYLAND LYDIA C. THORNTON JOHNSON MOO583 THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Douth Physician, disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the as use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 - Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Į Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ₫ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Magner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After injury work? 1 🗓 Natural 5 Pending WILL Accident Investigation 24 hours after deatl Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainter as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Controlling Nurse Practitioner to pre-29a. Certifie (Check within 2 29b. Signature and title of certifiq 29c. License number 1438 29 Name and address of person who completed cause of death (Item 23a) (Type, Print) EFE NSE NM GHWAY 445

Registrar
DHMH 17 Rev 7/2009

State

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Physician/ 19^{Day} 2010 Crittenden H. Walker, 8:00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Jefferson 4881 Pioneer Circle Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 XM 2 □ F Months Days Hours Min. Nov. 24, 1933 Mary land Director 211-26-3402 76 Usual Residence of Decedent show 10a. State 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 28a-f Jefferson Frederick Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21755 United States 4881 Pioneer Circle 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 XYes 2 NKorean
If Yes, Give Black, White, etc. 0 Completed by 1 Never Married 2 Married White 1 ☐ Yes 2 🛣No Specify: "natural", Specify. 3 Wildowed 4 Divorced Year or Dates. injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Construction Fencing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Crittenden Walker, Sr. Lena Lenhart 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i 21611 New Hampshire Ave., Brookville, MD 20833 Trena Walker/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of + Important: If ite any injury or other 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 4/26/2010 Frederick, Maryland Stauffer Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 621 Opossumtown Pike, Frederick, MD 21702 23a. Pad 1 Enter the disease, or complications that caused in shock, or heart failure. List only one cause on each line eath. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Parc Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 3 \square Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown completed filled in by the funeral director, page 2 should be detached Unknown by 23e. Did tobacco use contribute to the cause of death? Ď 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform ☐ Yes 2 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🗌 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After t Certificate: Hospital or Attending 24 hours after death. 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier ss of person who completed cause of death (Item 23a) (Type, Print eet Frederick 40

DHMH 17 Rev 7/2009

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

32. Registrat's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Michael Jerrell Wilson State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death Physician/ Month **Medical Examiner** 0628 hrs April 29, 2010 Micheal Micheal Jarre11 Wilson 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Civista Medical Center La Plata Charles 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director Country)Maryland 220-85-6439 1 X M 2 F 10-28-2009 6 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 Yes 2 No tant: If item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Myclical Examiner must be notified at once. Maryland St.Mary's Mechanicsville Imore, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29724 Finch Ct. 20659 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? White etc. 1 X Never Married 2 Married Yes White If Yes, Give Year 4 Divorced 1 Yes 2 X No specify: Š 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) n N/A N/A 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be David Allan Wilson Maria Elene Shizas မ 19a, Informant's Name/Relationship (Type, Print.) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Allan Wilson/Father 29724 Finch Ct., Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State ltimore, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State LaPlata UMC Cemetery 05-03-2010 Dentsville, MD Donation 5 Other Specify. 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Brinsfield-Echols Funeral Home, P.A. Box 128. P.O. Charlotte Hall. Approximate Interval 23a. Part I. Enter the disease, or complic ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line . Nedical Death Sudden unexplained death in infancy (SUDI) Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or es a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and for use as the burial - transit Physician/Medical UNPENDED AMENDED 27,28a-f,per ME g905 7/29/10 TT Box 68760, IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown the signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Ş 1 Yes 2 No 3 Probably 4 V Unknown Completed ricate has been s., page 2 should b 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of this certificate has performed death? ✓ Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certiff 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other 2 V ER/Outpatient 3 DOA 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Natural 1 Yes 2 X No 5 Pending the Fd 4/29/10 Fd 5:00 am 2 Investigation Accident filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2214 Finch Ct Mechanics ville, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be 3 Suicide determined House (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) April 30, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar

ORIĞINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No._ 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day Year **Physician** mes 216 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wenvio | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, April 4: 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country)
 WV 6. Sex **Funeral** Months Year, 1 XM 2 ☐ F 83 234-38-7573 4, Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, it a Marical Examiner must be notified at agnee. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17112 Lappans Road USA 21740 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1950–52 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: white Specify 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) meter test department Potomac Edison 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Wood Velvie Pitzer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith L. Wood - wife 17112 Lappans Road, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place. 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park 5/3/10 Hagerstown, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740 4 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** tor onavi 21/24 /Medical Due to (or as a consequence of) Examiner 8-may 15 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1 □Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 □ No 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ucujen +1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WH-20 368 Strell - Horastein

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)
APR 2 9

Registrar's Signature

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL 25, Day 2010 Year JOHN RICHARD WHITTINGTON 22:55 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** OLNEY MONTGOMERY MONTGOMERY GENERAL HOSPITAL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign B ^C**州**被於月and 8. Date of Birth 216-28-5320 **Funeral** Months Min. FEBURUTARY, YEST, 1928 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No SILVER SPRING MARYLAND MONTGOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a Funeral 2117 DRURY ROAD 20906 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2 ☐ No If Yes, Give 1 Q Ø Black, White, etc. Š 1 Never Married 2 Married If Yes, Give 1946-1947 Year or Dates. 1 ☐ Yes 2 No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) MANAGEMENT ANALYST U.S. GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ HAROLD OLIVER WHITTINGTON ELIZABETH LOUISE KIDEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. BLANCHE WHITTINGTON/ WIFE 2117 DRURY ROAD, SILVER SPRING, MD 20906 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Donation 5 Removal from State cemetery, crematory or other place) 4/29/2010 NORBECK MEM. PARK DLNEY, MARYLAND 21. Signature of Funeral Sorvice Licensee 22. Name and Address of FacilityMURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD m-00 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweel shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ hei-t ormestive disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death Other (specify) signed by the a 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy this certificate Yes • Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2. No 1 Yes 2 1. Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work?
1 Yes 2 No 1. Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 10055694 2010 PHYSICKS

8 + IVA State Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760

Records,

Division of Vital

108

Olacy,

20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUTHUL

32. Registrar's Signature

MLOX

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year :33 PM Patricia Mae Whitehead 2010 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomico the If Under 1 Year 7. Age (In yrs. last birthday) If Under 2/4 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗗 F Months Days Min. 6/25/1940 Yrs Virginia Director 215-38**-**1331 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2X No MD Worcester Girdletree 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5346 Onley Road 21829 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. white Completed 3 Widowed 4 Divorced Specify: Maryland 21215-00 the Medical 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic other permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, should be file h and Mental h ၉ Milton Crockett Beatrice Outen Page 1 and 2 should I ment of Health and Mc 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carlton Whitehead (husband) 5346 Onley Rd., Girdletree, MD 21829 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) First Baptist Cemetery 4/28/2010 Pocomoke City, MD 21. Signature of Funeral Service Licensee Professional Association Professional Association Mithu 107 Vine St., Pocomoke City, MD 21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARDIO MYOPATH disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? After this certificate has been signed by the atte funeral director, page 2 should be detached for Month Day 1 Yes 24 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page Yes Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence HOSPICIZ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 🔲 Natural 5 Pending Investigation
6 Could not be 1 🗌 Yes 2 No Accident 3 Suicide 4 Homicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3_ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 005

State Registrar 6 Huinn

31. Date filed (Month, Day, Year)

21802

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PU

32. Pegistrar's Signature

BUX

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2010 Month Physician/ Warren arry 0437 AM 22 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore University of Maryland Medical Center If Under 1 Year | If Under 24 Hrs. | Hours | Min. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □XM 2 □ F Months SEPT 26 1 NORTH CAROLINA Director 245-86-5699 58 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director PRINCE GEORGE'S 1 X Yes 2 □ No HYATTSVILLE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20784 USA 5615 QUINCY STREET Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 № Never Married 2 ☐ Married þ ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: If Yes, Give Specify: BLACK "natural", 3 Divorced 4 Divorced Completed Year or Dates er than "natur, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene.

Incortant: If item 27 is marked other than any i way or other traumatic event, the M any i way or other traumatic event, the M ones. Elementary/Seconday (0-12) College (1-4 or 5+) CONSTRUCTION PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **JESSIE** THOMPSON OWEN WARREN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KNIGHTDALE, NORTH CAROLINA 27545 DELORES MERRIRT/SISTER 508 MEADOW RUN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Donation 5 Other (Specify) LINCOLN CEMETERY 4/26/2010 BRENTWOOD, MARYLAND 21. Signal re of Feneral Service 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Dresumec Dheumonia Medical Due to (or as a consequence of): Examiner can cer, metastatic Small Sequentially list conditions. it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). Examir Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 for use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death 2 No ed by the a g 🗌 Unknown 9 Unknown P.O. | within 24 hours after death.

To the Funeral Director: After this certificate has been signed I completed filled in by the funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown MRSA mediport intection 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ✓ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work? 1 Natural 2 🗌 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 722955 22,2010 , mo 2 April 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Greene Street Baltimore, Maryland Dina Ismai

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 8 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Year 1:20 PM Neinae 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death General Hospital Montgomen Olney montgomer If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 💢 M 2 🗆 F Months Days Hours Min. New York 87 Director 098-12-6928 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho. 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Silver Spring 1 Yes 2 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Completed by Funeral 20906 3330 N. Leisure World Blvd., #227 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify 3

Widowed 4 □ Divorced Year or Dates. WW - TT 15 Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Television & Radio Cameraman/Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Florence Mollie Roseman ൧ Abraham Weinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debbie Goldkind, Daughter Balboa Court, Silver Spring, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, injury or 4 Donation 5 Other (Specify) Memorial Gardens 04/27/10 <u>Judean</u> Olney, MD OLODS Porchitisky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 Part 1. Serier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final Onset and Death Physician/ cation disease or condition Medical resulting in death) Due to or as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) burial-transit and Due to (or as a consequence of) attending physician I for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a, Was an Were autopsy findings available prior to completion of cause of cate has page 2 s autopsy death? certificate 1 Yes 2 WNo Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 옏 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after deau.

To the Funeral Director: After this and amounted filled in by the funeral di 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Yes 2 🗌 No Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Date signed (Month, Day, Year)

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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20832

18101 Prince Philip Dr., Olney, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Wilfong Jr. Gordon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland WMHS- RMC Birthplace (State or Foreign Country)

WV Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 □**x**M 2 □ F Months Days Hours Jun 5 [^]1928 215-20-5015 Director 81 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County within 72 hours after death with the Maryland Director Cumberland MD Allegany 1 □XYes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21502 USA 138 W. Third Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give WW 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married ģ 1 Tes 2 No Specify: Maryland 21215-0036 WW II white 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry grade completed) Ith and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med College (1-4 or 5+) Elementary/Seconday (0-12) Potomac Farms mechanic Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Zena (Bennett) Wilfond John Wilfong, Sr. permit. Page 1 and 2 should be Deportment of Health and Ment Important: If Item 27 is marke any injury or other traumatic once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1204 Back Creek Loop Solomons MD 20688 19a. Informant's Name/Relationship (Type, Print) daughte Carol Logan Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Temation 3 Removal from State Scarpelli Funeral Home, P.A. 5/6/2010 MD Cresaptown 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Full Full Home, PA 108 Virginia Avenue: Cumberland, MD 21502 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. P. 1. Enter the dise se, complications that caused nock, or heart failure. Lift only one cause on each line Approximate Immediate Cause (Final PNEUMONIA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** ROLD CANCER METASTATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 2 No signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 2 00 1 Tyes 24b. Were autopsy findings available 24a. Was an prior to completion of cause of page 2 s autopsy performe Yes 2 No this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Division of Vital director, Be 1 Department 2 ER/Outpatient 3 DOA 1 🗌 Yes 2 X No ပ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 🗌 Yes Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 0025406 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OWBROOK RD CLIMPFRI M.D 31. Date filed (Month, Day, Year) Registrar's Signature State

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DHMH 17 Rev 7/2009

Registrar

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		Registrar 1. Decedent's Name (First, Middle, Last)				imodic or	Death	2. Date of D	eath	1 0	3. Time of Death
Physici /Medic		Andrew Louis Wat	kins, Jr	•				April	20 ,	2010	12:20 a ^M
Examir		4a. Facility Name (If not institution, give s	treet and number)			4b. City, Town, o	r Location of D	eath	4c. Coun	ty of Death)
<i>y</i>		Anne Arundel Med					apolis				rundel
Funeral		5. Social Security Number 6. Sex	7. Ag	e (In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, E		9. Birth Coι	place (State or Foreign untry)
Director		Usual Residence of Decedent		81				May 1	3 , 1928		Maryland
yland how		10a. State 10b. County		10c. City, Tow		cation					10d. Inside City Limits
e Mar 3a-f si	cto	MD Anne Ari	ındel	Arn	old						1 □Yes 2 🙀 No
th with th 23a or 29	al Director	10e. Street and Number 987 Forest Drive				10f. Zip Code	21012		10g. Citizen o	f What Cou USA	-
If E. 12. 13. 10. 10. 10. 10. 10. 10. 10. 10. 10. 10	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent I Armed Forces? 1 X Yes 2 ☐ N If Yes, Give Year or Dates: I	Νo			lispanic Origin an, Mexican, P Specify:	? (Specify Yes or Nuerto Rican, etc.)	o- 14. Ra Bl Spec	ack, White,	ican Indian, , etc. iite
hin 72 hours e. an "natural", Medical Ex.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5			lent's Usual Occup kind of work done DO NOT use retired		working	16b. Kind of	Business/Ir	ndustry
ygien ygien t, the	Con	10			She	eet Metal					cademy
12 should be filed within 72 h and Mental Hygiene. 7 is marked other than "natur traumatic event, the Medical	To Be	17. Father's Name (First, Middle, Last) Andrew Louis Wath	kins, Sr.					Name (First, Middl res Marga		-	
2 sho h and is m		19a. Informant's Name/Relationship (Typ	·	19t		-		r Rural Route Num			ip Code)
les 1 and 2 of Health of item 27 is		Ruth A. Watkins/Wi	ife	20h Blace o		7 Forest			MD 21		Town State
Pages nent of h int: If ite		1 ⊠ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	I _		sition (Name of natory or other place	_ :	ril 22,		-	
		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		Glen		n Memoria Name and Addre	- 1	2010	Glen I	20T11T6	=, MD
permi Depar Impo any ir		21. Signature of Juneral Service License	е		Ba	rranco & 5 Gov. R.	Sons,	P.A. Ser	verna Pa	ark Fi	uneral Home MD 21146
Physician /Medical Examiner	ner	23a. Faf1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, in arry, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Due to (or as	a consequence	V)c	er the mode of dyir	ng, such as cai	rdiac or respiratory	Man Dise	Te .	Approximate Interval Between Onset and Death
eath certificate be executed attending physician and for use as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence	of):						
The law requires that the death certificate ate has been signed by the attending phys bage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death] Ectopic pregnanc] Other <i>(sp</i> ec <i>ify)</i> _	у			Date of delivery	very Day Year
e law requires that the de has been signed by the le 2 should be detached	þ	Part II. Other significant conditions con	tributing to death be	ut not resulting i	n the ur	nderlying cause giv	en in Part I.		tobacco use co]Yes 2 ☐ No		the cause of death? bably 4 Unknown
ר The law וי ficate has be r, page 2 sh	Completed							per 1 □ Yes	opsy formed? 2 Z No	o. Were aut prior to co death? 1 □ Yes	topsy findings available completion of cause of 22 No
stcia certi irecto	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	ospital:			Oth		Death (Check only			
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Attending Physician: r death. ector: After this certific by the funeral director,	atio	1 datural 5 Pending 2 Accident investigation	(Month, Day	y, Year)	Injury		ڏ? Yes 2∐No				
al or Atte s after des al Directol ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injubulding, etc.	ury - At home, fa c. <i>(Specify)</i>	ırm, stre	eet, factory, office	-		(Street and Nur own, State)	nber or Rui	ral Route Number,
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical (29a. Certifier (Check only one) 1 Certifying Phys	ician: To the best of er: On the basis of and manner sta	f examination ar	e, death	occurred at the tile restigation, in my c	me, date and p pinion, death	place, and due to the	e cause(s) and e, date and place	manner as e, and due	stated. to the cause(s)
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4×1		30. Name and address of person who co	PSU K	eath (Item 23a)	Type,	ve An	wele	1 Mea	11(4)	(a	ten
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to di		191	Decedent's Name (First, Middle)	dle, Last)			Timoato or	Douth		2. Date of	Reg.	No.		3. Time of Death
	Physic		Margare	+ н Wa	mpler					Apri	1 22	Day 2010	Year	10:15 p ^M
	/Medi Examii		4a. Facilify Name (If not institution				4b. City, Town, o	r Location o	of Death	-1		4c. County		<u> </u>
C.J.			Homewood @ Cru	mland Far	ms Healt	th Care	Frede	erick				Fre	deri	.ck
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthday)		If Under Hours	24 Hrs. Min.	8. Date of	of Birth			place (State or Foreign
0.00	Director		193-16-7806	1 □ M 2 🙀 F	86	Yrs.	Monard Bayo	110010	IVIII I.	Oct	18,	1923	Penr	sĺyvania
	and w		Usual Residence of Decedent 10a. State 10b. Count	hv	10c. C	ity, Town or Lo	ocation							10d. Inside City Limits
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	r 28a-f show notified at	Director	MD Fred 10e. Street and Number	<u>erick</u>		Frec	lerick 10f. Zip Code				10a	Citizen of W	hat Cou	ntry?
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	er death items 2: ner mus	Funeral	7407 Willow R 11. Marital Status	12. Was D	ecedent Ever in U	U.S. 13.	Was Decedent of H If Yes, specify Cuba	702 Iispanic Ori	igin? (Sp	ecify Yes	or No-			can Indian,
9	72 hours affer death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at		1 Never Married 2 Ma	rried 1 ☐ Ye	Forces? s 2 No					Rican, etc)		k, White,	etc.
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Z	should nd Me mark matic	٥	Peter Huncha 19a. Informant's Name/Relation			19h Maili	ng Address (Street			JSCAL al Boute N		ity or Town	State Zi	n Code)
$\mathbf{\Sigma}$	nd 2 %		Sally Smith	Daughter		1	Dagerwing			ederi			703	0 0000)
ē,	ss 1 and soft Health item 27		20a. Method of Disposition	Daugricon			osition (Name of matory or other place			Date		Location - 0		own, State
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E.			23a. Part1. Enter the disease, of shock, or heart failure. List	or complications tha	t call ed the dea	ath. Do not en	ter the mode of dyir	ng, such as	cardiac	or respirate	ory arrest,			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a	ronic	obsli	uctive	rul-	non	ary	Di	can		Onset and Death
1	/Medical		resulting in death)		o (or as a conse					11		corp	-	σ,φ η χ
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ğ	w require been sig should b	ed t									1 ☐ Yes	2 No	3 ☐ Pro	bably 4 Unknown
Records,	- 0 -	Completed									Was an	24b. W	Vere auto	opsy findings available
m m	: The law cate has l	ا ق								1 ₀ Y	autopsy performed 'es	1? d	eath?	ompletion of cause of 2□ No
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ū	ding Physician: After this certific funeral director,		27. Manner of Death Natural 5 ☐ Pend	ing (M	te of Injury onth, Day Year)	28b. Time o Injury	Wor			28d. Desc	ribe how i	njury occurre	∍d	
sio	Attending r death. ector: After sy the fune	cati	2 Accident invest	tigation				Yes 2						
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)	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only a Medica one)	I Examiner: On the	basis of examin	nation and/or in	vestigation, in my o	pinion, dea	ath occur	red at the	time, date	and place, a	and due	to the cause(s)
	To the Hi within 24 To the Fi complete	Me	29b. Signature and title of certifi	jer	-		29c. Licens	e number			29d.	Date signed	(Month,	Day, Year)
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1	At 511		30 Name and address of person	n who completed ca	use of death (Ite	m 23a) (Type,	Print)		D			1	12.	70.2
<i></i>	5"		LEARBEN 8	5 CANUM	rig	169.	1 J Druc	10	rR	909	R(CE	, MD	41	102
	Sta Registr	ite ar	30 Name and address of person 31. Date filed (Month, Day, Year APR 2	6 2010	Registrar's Sign	A. A.	back	•						

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vd			For State Registrar		State of	Marylan	u / Dep	artificat	L OI I	icaiiii d	and iv	neniai n	ygie	20	10	14964
			Registrar Decedent's Name (First, I	Middle, Last)					0 01 1			2. Date of I				3. Time of Death
	Physici /Medi		Charles Le	ola Wi	11iams	, Jr.						April	2	Day :	20^{10}	07:20 AM
	Examir		4a. Facility Name (If not inst.	itution, give s	treet and num	ber)		4b. City,	Town, or	Location of	of Death				ty of Death	<u></u>
			Elkton Care					ļ	E1k		2411				Cecil	
	Funeral Director		5. Social Security Number 219–18–4296		M 2□ F 7	7. Age (In yrs. I	ast birthday Yrs.	Months	Days	If Under Hours		8. Date of E (Month, May 18	Birth Day, Ye 1	925	9. Birth	place (State or Foreign ntry) Marylar Sinia
	land ow		Usual Residence of Deceder 10a. State 10b. Co			10c. City	y, Town or L	ocation								0d. Inside City Limits
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	or 28	Director	10e. Street and Number					10f. Zip					"		f What Cour	
	ath w		618 West 01d						2190					_	State	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a My lical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ 3 □ Widowed 4 □ Divo	Married	Armed Ford	2 No		Was Dece If Yes, spe 1 ☐ Yes		lispanic Ori an, Mexican Specify:		ecify Yes or I Rican, etc.)	No-	14. Ra Bl Spec	ace - Americ lack, White, hify: Wh:	etc.
9	2 hour		15. Dec	edent's Educ	ation	183.743-4	16a. Dece	edent's Usu	al Occup	ation			16b	. Kind of	Business/In	dustry
Baltimore, Maryland 21215-0036	i within 72 giene. r than "n	Completed	(Specify only r Elementary/Secondary (0- 12	<u> </u>	completed) College (1-4	4or 5+)	(Give life. We1	kind of wo DO NOT u der	rk done o se retired	during most i)	t of work	ing		Gove	rnment	=
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lar	2 sho n and 'is m raum		19a. Informant's Name/Rela Margaret Wil		. '	60	1				_	ah Tate Ke	B aa Ci	ty or Tow	n, State, Zij	Code)
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	/Medical		disease or condition resulting in death)	a a.	Due to (o	LUN(Anci	No M	A						unknown
	Examiner		Sequentially list conditions	b.		CAR	JUNA	Ay	AR	TEM	Di	Sean				unknown
1	ed sit	Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	2	Due to (5	r as a consequ	ianea off):	7		U					- 1.4	
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687	ificate g phys	edic		d.												
Division of Vital Records, P.O. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	t i	1 ☐ Live bir	ome of pregna rth 2□Fetal ant at time of d wn	death 3	□ Ectopic p □ Other (s)		у			-		Date of deliv	ery Day Year
σ.	that ned by deta		Part II. Other significant con	nditions con	ributing to dea	ath but not resu	ulting in the u	underlying o	ause giv	en in Part I.		23e. Di	d tobac	co use co	ntribute to t	he cause of death?
rds	quires an sign uld be	ed by										11	Yes	2 🗌 No	3☐ Pro	pably 4 ☐ Unknown
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ita	ilan: ertifica ctor, p	Be C	25. Was case referred to me examiner?	dical						26. Place	of Deat	1 □Yes h <i>(Check onl</i>)		140	1 🗀 162	2 140
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n c	ing P	.: O	27. Manner of Death 1 Natural 5 □ Pe	ending	28a. Date of (Month	f Injury , <i>Day, Year)</i>	28b. Time of Injury		8c. Injur Worl			28d. Describ	e how i	njury occi	urred	
)ivisio	or Attend after death Director; / in by the f	Certification: To	3 ☐ Suicide 6 ☐ Co	vestigation ould not be etermined	28e. Place o building	of Injury - At ho g, etc. <i>(Specif</i>)	me, farm, st	M reet, factor		Yes 2⊡I		28f. Location City or 7	Stree own, S	t and Nur tate)	mber or Run	al Route Number,
П	Hospital	Medical Ce				pest of my knownsis of examination										
	o the	Mec	29b. Signature and title of ce			si siateu.		29	. Licens	e number			29d.	Date sign	ned (Month,	Day, Year)
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10	LIVA		30. Name and address of pe	rson who cor	npleted cause	of death (Item	23a) (Type 26 A	Frint) E·H	aH.	STREE	et, 1	ELKTO	2.	пр	2192	1
	Sta		31. Date filed (Month, Day,		32. Re	gistrar's Signat	ture									
	Registr	ar	AP	R282	910	mur	1.	box	1							

DHMH 17 Rev 1/2001

ORIGINAL

10-031	38		
Phyllis	Wilkins	White	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 4965 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar			C	ertifica	ite of	Death				Reg. No).			
Physicia	an/	Decedent's Name (First	Middle,L	ast)						12	2. Date of De	eath			3. Time of Death	_
ledical Exami		Phyllis A	าก พี	hite							Month April 22,	Day 2010	Yea		1317 hrs	
		4a. Facility Name (if not in			umber)		41	b. City, Town, o	r Locatio	n of Death			c. County o	f Death		_
		572 Village Cour						Salisbury					Wicomic	0		
Euporal		Social Security Number	16	Sex	7. Age (In yrs	. last birth	ndav)	If Under 1 Yea	ar I If Ur	der 24Hrs.	8. Date of E	Birth/MN	I/DD/YYYY	9. Birt	hplace (State or	_
Funeral Director								Months Day	_		1			Foreign	n	
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* any		10a. State 10b. C	,			ty, Town o		on							10d. Inside City Limits	
and shor	ក	MD Wi	comi	CO	Sal	isb	ury								1 X Yes 2 No)
Maryland 28a-f show	ect.	10e, Street and Number					I	10f. Zip Code				10g. Ci	tizen of Wh	at Coun	try?	
he N	Ē	572 Villa	70 C	ourt			l	21801				TIC 7				
with 1	펼	11. Marital Status	16 0		cedent Ever in	U.S.	13. Was	Decedent of Hi	ispanic C	rigin? (Spe	cify Yes or N	<u>US</u> 2		- Americ	can Indian, Black,	_
eath item	Funeral Director	1 Never Married 2	Marrie				If Ye	s, specify Cuba	n, Mexic	an, Puerto R	ican, etc.)		White	, etc.		
ter de		3 Widowed 4	Divorce	1 Yes ed If Yes, Give Ye	2 X No ar		1 .	Yes 2 X No	s <i>peci</i>	fv:			Specify:B	lac	:k	
irs af ural min	ð	15. Decedent's Education		or Dates:		16a. D		s Usual Occupa			rk done	16b.	Kind of Bus		<u> </u>	_
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5-00 led with Hygiene other	0	17. Father's Name (First, I	liddle La			TAGI	11 1111	SCIAL			• First, Middle				<u>e</u>	_
15-C					-								r ourname)			
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	Be C	Nathaniel 19a. Informant's Name/Re			Sr.	10h	Mailing	Address (Stre			ampbe		ity or Town	Ctato	Zin Codo\	-
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Z that a	- 1	Robert Wh: 20a. Method of Disposition	<u>.te/</u>	Son	1 201	Diagonal	Dianasit	ion /Nome of se	<u>rst</u>	Ave,	<u>New</u>	Yor	k N	<u>Y 1</u>	0033	_
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9 2 2 4 4	1	MX		2 5	10	Sr.	Ber	nnie Sr Meral F	nitr	Sal	isbur	v.	MD 2	180	1	
Physician	\neg	23a. Part I. Inter the dise	se, or con	nplications that	caused the dea	th. Do not	enter the	e mode of dying	, such as	cardiac or r	espiratory a	rrest, sh	ock, or hea	rt	Approximate Interval	
Modical	Į	failure. List only one		each line. _{a.} Cardiac Ta	mnonada										Between Onset and Death	J
Examiner		Immediate duse (Final d or condition resulting in de			a consequence	of):								_		_
	- 1			b Aortic Diss		,-										
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	Examiner	eause. Enter Underlying ((Disease or injury that initi		c. Hypertens			Disea	se						- 3		
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di di di	ja.	past 12 months?	it iii tiie	D	birth nant at time of e	44-	=		Ecto	oic pregnand	Э		Month	D	ay Year	
Box 687 e death certific the attending of	sicial	1 Yes 2 ✔ No 9	Unknov			death 5	Othe	er (Specify)								
the c	Phy	Part II. Other significant	onditions			regulting	in the un	derlying cause	given in	Part I	23e Did	tobacco	use contrib	ute to t	he cause of death?	_
ires that the signed by the detach	<u>ā</u>	Ture II. Outor Significant	on and one	o contributing t	o death but not	resulting	iii tric dir	donying cause	giverini	art i.		_		_	ably 4 🗸 Unknown	
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eco he law ite has ige 2 sl	ξ		,								perf 1 ✓ Yes	ormed?		eath?	2 No	
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Phy er th	2	1 Yes 2 N)	28a. Date	_		ime of Inj		ıry at Wo		8d. Describe	_				-
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ivision or Attencather death Director:	gţ	2 Accident	Investiga	ation	A A						06 1	/011		D	- D- 4- No-sh Cit.	
Division of Vital Records, at or attending Physician: The law requires after each. The law requires are the continued of the physician of the physician of the funeral director, page 2 should led in by the funeral director, page 2 should.	Certification:	3 Suicide 6	Could no	ot be		nome, rai	m, sueet,	, factory, office l	bullaing,	etc.	or Town,		and Numbe	r or Kur	al Route Number, City	j
Div ospital or hours afte uneral Dis ly filled in	٥	4 Homicide	dotoriiii	(Specify)						77						4
王 至 三 5	핑	TOTAL DITTY		ician: To the be	-				,							
Di To the Hospital within 24 hours: To the Funeral completely filled	Medical	2 👿		er:On the basis and manner s		and/of In	vestigatio				ne une, uate					
	Σ	29b. Signature and title of	ertifier					29c. Licens		er		1			th, Day, Year)	
		Cana	e 14	tail	an			O.C.	M.E.			Apı	il 27, 20	10		
-	- 1	30. Name and address of p	erson who	o completed cau	se of death (Ite	m 23a)										
	1	Carol Allan, MD	Assist	tant Medical				treet, Baltim	ore, M	D 21201						11/2
St	ate	31. Date filed (Month, Day,		32. R	gistrar's Signa	ture	1	48								
Regist	rar	WAY	10:	2010 L	evena	Ø.	190	Lices								١

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			For State	State of I	Marylan	•				ental Hy	giene	0.1.0		966
			Registrar			Cen	tificate o	f Death			Reg. No. 🦾	UIU	l Li	300
	Physicia	n/	Decedent's Name (First, Middle, La		r - T7 .	. 1				2. Date of Dea Month	ath Day	Year	3. Time o	
	Medic Examin		4a. Facility Name (if not institution, giv	Edna M		ra	4b. City, Town	n, or Location	n of Death	May	1 4c Cou	2010 nty of Deat		P
	LAGIIIII	CI	Union Hospital		,		E1kt					ecil		
	Funeral		5. Social Security Number 6.	Sex 7.7	Age (In yrs. la	ast birthday)	If Under 1 Ye	ear If Unde	er 24 Hrs. Min.	8. Date of Birt	h	9. Birt	thplace (State	or Foreign
	Director		219-28-3387	1 □ M 2 💢 F	76	Yrs.	WOTHERS DO	iys Hours	IVIII I.	April 17	,′°1934	Mas	sachus	etts
	nd how at	ř	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Loc	ation						10d. Inside 0	City Limits
	taryla 3a-f s iffed	Director	Maryland Cecil		l No	orth Ea	ast						1 □ Y€	es 2 🗓 No
	or 2	Ö	10e. Street and Number				10f. Zip Coo	de			10g. Citizen	of What Co	untry?	
	s 23a	Funeral	96 Willard Drive	9			219	901			Uni	ted S	tates	
	death item	Fur	11. Marital Status	12. Was Deceder Armed Forces	?	S. 13. W	/as Decedent of Yes, specify C	of Hispanic C Cuban, Mexic	rigin? (Spec an, Puerto F	cify Yes or No- Rican, etc.)		Race - Ame Black, White	rican Indian,	
36	after al", or xami	d by	1 ☐ Never Married 2 ☐ Married 3 💢 Wid owed 4 ☐ Divorced	1 Yes 2 If Yes, Give		1	☐ Yes 2 👿	No Specif	fy:		Spec	16.0		
9	hours natura ical E	lete	15. Decedent's				ent's Usual Oc				16b. Kind o		nite Industry	
215	in 72 e. nan "r	mg	(Specify only highest g Elementary/Seconday (0-12)	rade completed) College (1-4 c	r 5+)	(Give k life. DC	ind of work do NOT use retir	ne during mo red)	ost of workin	ng			al Mot	or
21	y with ygien her th	Be Completed	12		·	To	ol Room					ufact	uring	
% Maryland 21215-0036	e filec ntal H ed ot ever	To B	17. Father's Name (First, Middle, Last)							(First, Middle,		ame)		
\ <u>\frac{7}{2}</u>	ould by mark mark		Harold Hamel 19a. Informant's Name/Relationship (Type Print)		10b Mailin	a Addraga /Sta			ne Racio		e State Zir	- Cadal	
Z Z	12 shouth an 127 is 27 is r trau		Mahlon G. Ward,				airway				19711	1, State, ZI ₁ .	o Code)	
Per 1) altimore,	1 and of Hee item		20a. Method of Disposition		20b. P	lace of Dispos	sition (Name of atory or other	f	D	ate		on - City or	Town, State	
timo &	Page nent c ant: If		1 ☐ Burial 2 🔀 Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec	⊒ Removal from Sta :ify)	te R.		s & Co.,		May 2010	6,	Wes	st Che	ester,	PA
3alt	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licer	isee ,	<u> </u>	22: H	Name and Ad	dress of Fac	ility r Fune	erals,				
S m	90 = 80		Morned -	8-Hul								MD	21921_	
8			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final			n. Do not ente	r the mode of o	dying, such a	is cardiac or	respiratory arr	est,		Approxima Interval Be Onset and	etween
0	Physician/ Medical		disease or condition resulting in death)	a	e a consequ	na.								- Dodan
0	Examiner			Due to (or a	is a consequ	erice oi).								
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	sonsequ	ence of):								
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bo	ate be executed ohysician and the burial-transit	edical Examiner	resulting in death) Last	` .	is a consequ									
760	cate be physicia the bur			■ d/	totho									
V 28	certific ding se as	M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcon	ne of <u>pr</u> egnar	ncy					234	Date of del	livery	
Ex	eath c atter d for u	by Physician/M	in the past 12 pronths?	4 🗌 Pregnan	t at time of d	ll death 3 🗌 leath 5 🗆	Ectopic pregr Other (specif)	nancy /)				Month	Day	Year
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100	law r has b e 2 st	Completed	MI.	, Hype	Mean	u				24a. Was autop		b. Were au prior to death?	topsy findings completion of	available cause of
~	r: The ficate r, pag	ပိ	25. Was case referred to medical	Eonkeli	<u>en</u>	PES		2 51 (5	11 (01 1	1 Tyes	2 No		2 No	
/ita	sicial certi	To Be	examiner?	Hospital:	ationt 2 X	R/Outpatien		Other:		o <i>nly one)</i> ne 5 □ Resid	t-n 6 🗆 6	Abor Coos	14.0	_
Division of Vital Record	g Phy er this neral c		27. Manner of Death	28a. Date of ir	niury	28b. Time of injury	28c. li	njury at work?		8d. Describe h			пуј	
on	endin eath. or: Aft he fur	fical	1 Natural 5 Pending 2 Accident Investigation	on	yay, rear)	injury		Yes 2	□No					
Visi	or Att fter de irecte n by t	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e. Place of I	njury - At ho etc. (Specify)	me, farm, stre)	et, factory, offi	ice	2	28f. Location (S City or Tow		mber or Rui	ral Route Nun	nber,
Ö	pital o		20-0-44	vaision. To the heat	of my lenous	adaa daath a	ocured at the	time date an	d place and	due to the en	uno(a) and ma	nner en ete	at a d	-
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Medical		ysician: To the best niner: On the basis o rse Practioner: To t	f examination	and/or investi	gation, in my o	pinion, death	occurred at	the time, date a	nd place, and	due to the	cause(s) and m	nanner stated.
	To the within To the comp	2	29b. Signature and title of certifier		2301 OF THY			ense number			29d. Date sig			
			In cee k	11 M	D		Do	1482	23		5/3	3/10		
	3		30. Name and address of person who	4 . 6 .	4	23a) (Type, Pi	rint)	- 41.	, 5 0	t. E/k	Cho.	L1.	1 110	9),
			JU CITU 31. Date filed (Month, Day, Year)	+ HSW	MP trans Signat	223	men	110	u ×	0. 211	NU	1000	1 -1	1
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DHMH 17 Rev 7/2009

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							Ce	rtificate	of D	eath		,	Reg. No	010)	14961	
	Dhysisi		1. Decedent's Name (First,	Middle, Last)							ate of Dec	eth De	v Ye	ar	3. Time of Death	
	Physici /Medio		Esther M.	Yoder										2010		2:06 AM	
	Examir		4e Fecility Neme (If not ins	titution, give	street end num	ber)			4b.	City, Town	n, or Location	n of Deeth	4c.	County of D	Deeth		
		Н	442 Dorsey Ho	otel Ro	d.						sville	е	G	arrett	:		
	Funeral		5. Sociel Security Number	6. Se		. Age (In yrs.	last birthday)	If Under 1 Months [If Under 24 Hours	Hrs. 8. D.	ate of Birt	h v. Yeer)	9.	Birthpla	ace (State or Foreign ry)	n
	Director		214-36-6550	11	□M 2⊠F		78Yrs.	I I I I I I I I I I I I I I I I I I I	Jujo	110010		ly 8				 Sylvania	
	р ,		Usuel Residence of Decede			10 0:											
	aryla	_	10a. State 10b. C	ounty			ty, Town or Lo								10	ld. Inside City Limits 1 ☐ Yes 2 🕱 No	
	M = M	5	MD Gar	rett		Gr	antsvi	lle								I 🗆 Tes 2 💢 140	
	1 th		10e. Street end Number					10f. Zip Co	ode				10g. Cit	izen of What	t Count	ry?	
	23e	<u>e</u>	442 Dorsey F	Hotel H	Rd.			2	1536				US	A			
	ep L	E E	11. Marital Stetus		12. Was Deced		I,S. 13.	Was Deceder If Yes, specify	t of Hisp Cuban.	anic Origin Mexican, F	n? (Specify Y	es or No-		14. Race - A Black, W			
0	parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mentel Hygiena. Important: if item 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	1 Never Married 2		1 ☐ Yes If Yes, Give	2 No		1□ Yes 25		Specify:				Specify:			
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Division	ath. r: Ath	atic		vestigation	, in the second	, , , , ,	,,	М		s 2 No)						
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$\overline{\Box}$	s efter	Certification:	4 - Homoloo		Dunding	, 010. (Op000)	37					, 0, , , , , ,	n Diane	,			
	To the Hospital or Atte within 24 hours efter de To the Funeral Directo completaly filled in by th		29a. Certifier 1	tifying Phys	sician: To the b	est of my kno	wledge, death	occurred at t	he time,	date and p	olace, and di	ue to the o	euse(s)	and manne	r as sta	ated.	
	the Ho hin 24 the Fu npletal	edicai	(Check only 2 Me	uicai Examir	ner: On the bas and manne	is of examina or steted.	uion ena/or in	vestigation, in	my opin	ion, death	occurred at	tne time, o	ate and	place, and	due to	tne cause(s)	
	within To th		29b. Signature and title of c	lifier	1			29c. L	icense n	umber			29d. Da	te signed (M	fonth, E	Dey, Year)	
			1		Mari	res.	W	1	25	21	181		40	RIL :	25	2010	
			30. Name and address of pe	erson who co	mpleted cause	of deeth (Iten	n 23e) (Tvpe.	Print)		(X)	- /			0	-	0,010	
	1	5	Gary L. Wago		//		o Walsh		Ste	. 4. (Cumber	cland	, MT	215	02		
<i>k</i> .	Sta	e	31. Date filed (Month, Day,	Year)	32. Re	istrer's Signa		La del	4	/ \			, . 11				
	Registra		APR	2920	110	men	p. 19										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3. 2010 April 23, **Physician** 8:30 p M Clayton Albert Zincon /Medical 4a. Facility Name (If not institution, give street and number) Examiner Assisted 4b. City, Town, or Location of Death 4c. County of Death Homestead of Sun Valley Carroll Living Sykesville 8. Date of Birth Month, Day, Year) NOV 24, 1911 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 X M 2□ F Months Days Hours Min. Mary land 98 Director 213-05-3141 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercises. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Sykesville 1 ☐ Yes 2 No Maryland Director Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 USA 110 Terrapin Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 M No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. ģ Specify: white 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Automobiles Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nancy Elizabeth Arnold John Daniel Zincon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 375 Kingsbury Way, Westminster, MD 21157 Mary Marzullo, niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4/27/2010 Finksburg, MD 4 Donation 5 Other (Specify) Evergreen Memorial Myers-Durboraw Funeral Home 21. Signature of Funeral Service License 22. Name and Address of Facility 91 Willis Street, Westminster, MD 21157 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheek, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cenebrovasc-lar Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown detached 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 Tes No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has page 2 s 2 No 1 ☐ Yes 1 Yes Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted Hospital: 1∐Yes 2No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4/26/2010 H53939 WJZ 6+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Babak Inanoel, Do; 218 Washinghon He 218 washington Heights Med Ctr; Westminster, MD 21157

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature

			Please Amend # 9,	e Type or Print in Bl 15 16a-b & 19a-b State of Maryland	lack Indelible In per AB g90	k. Ensure 3 5/10 10 Health and	All Copies	Are Legib	le.			
			1 - For State Registrar		Certificate of			Reg. No.				
	DI		1. Decedent's Name (First, Middle, La	·			2. Date of Dea	ath	3. Time of Death			
	Physicia Medio		ADRIAN	BREECE			Month	2 4 20	10 1721 AM			
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	and show	ō	10a. State 10b. County	10c. City, T	Town or Location				10d. Inside City Limits			
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21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	15. Decedent's i (Specify only highest g		16a. Decedent's Usual Occu (Give kind of work done	during most of war	rking I	16b. Kind of Busine				
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d 2	filed wi al Hygie d other event, ti	Be (17. Father's Name (First, Middle, Last)	2000	10/31/106	18. Mother's Nar	me (First, Middle, I	Maiden Surname)				
lan	l be fil fental rrked tic ev	욘	UNK				UNV	_	·			
Baltimore, Maryland	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Vernice Lynch)	Type, Prioti ase Manager	19h Mailing Address (Street 255 Rockvill		ral Route Number		Tie, MD 20850			
ē,	permit. Page 1 and a Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition		e of Disposition (Name of	St OLE	Date	20c. Location - City	y or Town, State			
m0	Page Tent o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 X Other (Spec	a ricinoval itolii otato	etery, crematory or other pla	ice)						
alti	permit. I Departir Importa any inju		21. Supplie of Funeral Pervice Licer Ronald S.	1500	22. Name and Addre	ess of Facility	rd: 655	W Roltin	ore Street			
	99 E 8 9		28a. Part 1. Enter the disease, or con-						- Street			
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∑ <	Phys r this eral dii	9: To	27. Manner of Death		t/Outpatient 3 □ DOA □ b. Time of 28c. Inju	4 ☐ Nursing F		ence 6 Other (S	pecify)			
ou c	nding ath. r; Afte e fune	icat	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	injury w <u>or</u>			,,				
Division of Vital Records, P.O.	r Atte er de recto by th	Certificate:	3 Suicide 6 Could not to 4 Homicide determined		e, farm, street, factory, office		28f. Location (Si City or Town	n (Street and Number or Rural Route Number,				
٥	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the bu			N)			10					
	Hosp 24 ho Fune eted f	Medical	(Check 2 L Medical Exam	vsician: To the best of my knowledg	nd/or investigation, in my opin	ion, death occurred	at the time, date ar	nd place, and due to t	the cause(s) and manner stated.			
	To the within To the somple	Σ	only one) 3 L Certifying Nui 29b. Signature and title of certifier	rse Practioner: To the best of my kn	29c. Licens			29d. Date signed (Me				
			4500-	Sh. D	D 6	6249		04,30	2010			
			30. Name and address of person who	completed cause of death (Item 23	a) (Type, Print)			`				
			31. Date filed (Month, Day, Year)	URAN, MD.	1500 FORES	T GEN	80 S.S	MD 2	20910			
	Stat Registra		MAY 1 3 20	32 Regištrar's Signature	backer							

10-03461 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amendate of Maryland Department of Health and Mental Hygiene Dana Michelle Brooks 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day May 4, 2010 **Medical Examiner** Dana Michelle Brooks 2000 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8675 Greenbelt Road, Apartment 102 Lanham Prince George's 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) **Funeral** 216-96-7024 40 Months Days Director Hours Aug.12,1969 2 X F Usual Residence of Decedent 10b. County PG 10a. State MD Oc. City, Town or Location 10d. Inside City Limits Greenbelt 28a-f show 1 X Yes 2 No altimore, MD 21215-0036 mit. Pages I and 2 should be filed within 72 hours after death with the Maryland spartment of Health and Mental Hygiene. portant: If item 27 is marked other than "natural", or items 23a or 28a-f show jury or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 20770 10g. Citizen of What Country 8675 Greenbelt Rd. Unit 102 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 2 X No Yes 4 X Divorced Specify: Black 3 Widowed If Yes, Give Year 1 Yes 2 X No specify: ੬ Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) 12th N/A 1yr N/A17. Father's Name (First, Middle, Last 18.Mother's Name (First, Middle, Maiden Surname)
Phyllis Foust Michael Brooks Be 19a Informant's Name/Relationship (Type, Print)
Phyllis Mohamed/Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8675 Greenbelt Rd. Unit 102 Breenbelt Greenbelt Breenbelt MD Greenbelt 20770 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State rinal Journey 1 Burial 2 K Cremation 3 Removal from State 5/12/10 Woodbine, MD 4 Donation 5 Other Specify. 22. Name and Address of Facility Charisse N. Woods 21 Signature of Funeral Service Licensee 700 Edmondson Ave., Balto., MD 21223 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Approximate Interval Between Onset and /Medical Death Morphine intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical X UNPENDED AMENDED 23a, PII, 27, 28a-f, per ME g903 5/17/10 TT sician burial The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, IF FEMALE: 23b. Was decedent pregnant in the phy: the b 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 3 Ectopic pregnancy Fetal death Day Year past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Sickle cell disease Completed has been si 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? ✓ Yes 2 No death? certificate 1 🗸 Yes 2 No this certifi 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 V Yes After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death I or Attending P after death. I Director: After ed in by the funera 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 X No Fd 5/4/10 Fd 7:55 pm 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 📙 6 X Could not be Suicide within 24 hours aft To the Funeral Di completely filled in or Town, State)8675 Greenbelt Road determined (Specify) 4 Homicide Residence Lanham, 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated.

State

OCME

30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD - Assistant Medical Examiner

du

strar's Signature

ORIGINAL

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

May 5, 2010

Registrar

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** AM James Covert Bass 1.31 MAY 0 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A HOSPITAL St. AGNES BAI TIMORE 8. Date of Birth (Month, Day, 122) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** . Year) 933 Days Months 1 XM 2 ☐ F 76 Maryland 217-30-4565 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Midical Examiner must be notified at 1 X Yes 2 □ No Director N/A MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with in nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or: 21223 United States 1009 Parksley Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo White Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tavern Owner Food & Beverage 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alberta D. Seltzer Walter Carl Bass 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health at Important: If item 27 is any injury or other trau 1009 Parksley Avenue, Baltimore, MD 21223 Eda A. Bass - Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Tread ow rated grether place) 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 5-13-2010 Elkridge, MD Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer Service Lice 22. Name and Address of FacilitAmbrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PHEVMONIA Physician WEEKS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ONGESTIVE CARDIAC FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a Ö ☐Yes 2☐No 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t performed this certificate 1 ☐Yes 2 ☐No 1 🗆 Yes 2 No Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ↑☑Inpatient 2 ER/Outpatient 3 DOA Certification: To of 28a. Date of Injury (Month, Day, Year) Director: After that in by the funeral 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 44 hours after death. 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 29c. License number 0 Verta MAY, 10. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD, SANGITA VERMA, St. AGNES HOSPITAL 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last 1:35 AM **Physician** 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner N/A Frankford Nursing & Rehabilitation Baltimore 8. Date of Birth Month, Day, Year) May 15, 1963 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday Social Security Number 6. Sex **Funeral** Days Hours 1XM 2□F 46 Yrs. Maryland 218-90-1542 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show be notified at 1 X Yes 2 ☐ No Baltimore Director Maryland N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be r USA 21205 506 North Port Street by Funeral within 72 hours after death Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? I □ Yes 2 XNo f Yes, Give 1 XNever Married 2 ☐ Married Specify: Black 1 ☐ Yes 🎾 No Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Apartment Building permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygis Important: If item 27 Is marked other any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marcella H. Banks UNK. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1104 Glemsford Road Essex, Maryland 21221 ShaOuetta Nottage, Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Metro Crematory Inc. 05/11/10 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that claused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final hysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Miknown icate has been sig 7, page 2 should b Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ 16 24a. Was an autopsy performed 2 No Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 2 No Medical Certification: To 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 24 hours after death.

Funeral Director: After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. the the the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Noverda

and address of person who completed cause of death (Item 23a) (Type, Print),

nam words Arod.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) Year EUNICE BANNON 10:45A 2010 May 11 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Baltimore St. Joseph Nursing Home Catonsville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Days 215-46-5530 98 Feb. 4, 1912 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 X No Catonsville Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 USA 1222 Tugwell Drive 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married $_{\it Specify:}$ White 1 ☐ Yes 2 🎦 No Specify. 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George W. Rosenberger Edith Mae Dorsey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 145 South Rt. 73; Braddock, New Jersey 08037 Elizabeth M Clark Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 5/14/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. of Funeral Service Lice 1630 Edmondson Avenue: Catonsville MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death THRIVE

Physician /Medical Examiner

Physician

/Medical

10a. State

MD

Director

Funeral

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Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic every any injury or other traumatic every once.

To the most after death.

To the Funeral Director: Aft

or Attending Physician: The law requires that the death certificate be execute Division or Vital Records, P.O. Box 68760

disease or condition resulting in death)	FIAILUICE I	OTHE			SIX YEARS				
resulting in death)	puentially list conditions. by, leading to immediate se. Enter Underlying use (Disease or injury initiated events Due to (or as a consequence of). Due to (or as a consequence of).								
Se uentially list conditions, if any, leading to immediate cause. Enter Underlying									
that initiated events resulting in death) Last									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 W No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of del Month	ivery Day Year				
Part II. Other significant conditions con	ntributing to death but not resulting in the ur	nderlying cause given in Part I.		use contribute to	the cause of death?				
			24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of				
25. Was case referred to medical		26. Place of De	eath Check onl one						
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	t 3 DOA Other: 4 Nursing	Home 5 ☐ Residence	6 □Other (Spe	cify)				
27. Manner of Death 1	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	ury occurred							
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, Sta	and Number or Ri te)	ural Route Number,				
29a. Certifier 1 Certifying Phy (Check only one)	iner: On the best of my knowledge, death iner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and pla vestigation, in my opinion, death oc	ce, and due to the cause curred at the time, date a	(s) and manner as and place, and due	s stated. e to the cause(s)				
29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Mont	th, Day, Year)				

Registrar

State

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ss of person who completed cause of death (Item 23a) (Type, Print)

-Unc Fre Obruck RO, Suite 204, CATONSUILLE, MD

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Bepartment of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month 559 A M **Physician** Jerauld A. Berlin MA 冬 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner AGNES EALTheare BALTIMOre 5. Social Security Number 5541 220-34-5341 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1**⊠**M 2□ F 9/13/39 Maryland 70 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Department of Heath and Mental Hygiene. Important: If frem 27 is marked other than "natural" --- any injury or other traumatic events. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 XYes 2 □ No Funeral Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21229 512 North Chapel Gate Lane 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces: 1 ★Yes 2 No If Yes, Give Year or Dates:1960-62 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Self Employed 12 Entrepreneur 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lorraine Schmelz Sidney Lee Berlin ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 512 North Chapel Gate Lane Baltimore, Md. 21229 Mrs. Arlene Berlin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemeterv: 5/13/10 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Ligensee Loudon Park Funeral Home Baltimore, Maryland 21229 3620 Wilkens Ave. 23a. Part 1. Enter the disease, or shock, or fleart failure. List mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Immediate Cause (Final Atherosclerotic Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off: Physician/Medical Examiner burial-trans Due to (or as a consequence of): physician the been signed by the attending I should be detached for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Ö 9 I Inknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ 6 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 s page 3 performed certificate 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending 1 □Yes 2 □ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00058141 2010 rellen MO e and address of person who completed cause of death (Item 23a) (Type, Print) 21229 State Registrar

ERAI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ May 1, 2010 3:55 P Dorothy Angela Cook Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore 3602 Glenarm Avenue 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 🗆 M 2 💢 F June 1/2 Day 1926 **Mary**Yand Director 220-22-3046 Yrs Usual Residence of Decedent 10b. Count Town or Location Baltimore permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10d. Inside City Limits by Funeral Director Maryland other than "natural", or items 23a or 28a-f s rent, the Medical Examiner must be notified 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21206 USA 3602 Glenarm Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc 1 Never Married 2 X Married 1 Yes 2 No Baltimore, Maryland 21215-0036 white 1 Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Tekla Witkowski Joseph J. Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2311 Kings Arms Drive Fallston Maryland 21047 David Cook/ son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 5/14/10 Baltimore Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Retween Onset and Death Immediate Cause (Final ூnysician/ Runcreatic disease or condition resulting in death) Medical Due V (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of). attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes has been signed 2 should be 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No After this certificate he funeral director, page Yes 2 🗌 No Be Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 No 5 Residence 6 Other (Specify) ည 1 Tyes 4
Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1-Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director: / 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🖹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signatur

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month :30 AM ma Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** altimore Samaritan Home If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) Dec. 01, 1929 1 🔀 M 2 🗆 F Months Director 80 Maryland 216-24-9483 or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Examiner must be notified at Director Maryland Baltimore Carney 1 Ves 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 2905 Duncan Lane 21234 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 14. Race - American Indian 11. Marital Status Black, White, etc. ò 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify: White Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Yard Master CSX Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Thomas Callis, Sr. Ethel M. Groves other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2905 Duncan Lane Carney, Maryland 19a. Informant's Name/Relationship (Type, Print) Carney, Maryland 21234 Mary Callis (Spouse) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel Bel 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or 14,2010 Forrest Hill Air 21. Signature of Funeral Service Licenses

23a. Part 1. Enter the disease, or complications that caused shock, or Hear failure. List only one cause on each line. Immediate Cause (Final disease or condition 22. Name and Address of Facility **Evans Funeral Chapel**8800 **Harford Road** or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death enysician/ disease or condition resulting in death) Medical Due to (or as # consequence of) Examiner weel Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated expense.) Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 2 X N 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 2 No 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 5 Pending 2 🗌 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3066 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laven 560 doen Blid 31. Date filed (Monti 32 Registrar's Signatur State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 12:25 AM CATHERINE DOUGLAS Mac 2010 8 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE JOHNS HOPKINS BAUVIEW MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 6. Sex **Funeral** Days Hours Min. 1 M 2 F Months JULY 18, 1935 2/6-32-0109 Usual Residence of Decedent Director MARYLAND filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Mudical Examiner must be notified at 1 Xes 2 □ No Director BALTIMORE MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 5522 FRANKFORD AVENUE 21206 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Ye ar or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 TNo Specify. Specify: BLACK 3 ₩Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FACTORY LABOKEK 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ MATTIE MILLARD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTO, MD LILVO
20c. Location - City or Town, State FRANK FORD AUE. BRENDA RICHARD - DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State METRO CREMATORY MAY 15, 2010 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
CALUIN L. WILLIAMS FUNERAL SERVICE, P.A. 21. Signature of Funeral Service Licensee CL Ma 270 FREDHILTON PASS BALTIMORE, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 4 days Cardiac disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of): of Vital Records, P.O. Box 68760, attending physician for use as the hirial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performed? 1 Yes 2 No page director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To nours after death.

neral Director: After this

filled in by the funeral d 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I 29a. Certifier 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

3

DHMH 17 Rev 1/2001

State Registrar ASHUL GOVIL

31. Date filed (Month, Day, Year)

4940 EASTERNAVENUE.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

RES-000

BALTIMORE MO

2010

21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10c per fh /8903 5-13-10 yeth and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:46 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Baltimore Medicaller lland 7. Age (In yrs. last birthday) If Under 1 Year If Linder 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2**X** F Hours 011/24/1957 Mary land Director 219-62-5714 53 Usual Residence of Decedent or 28a-f shov 10a. State 10c. City, Town or Location at 10d. Inside City Limits Director Examiner must be notified 1 X Yes 2 No **Baltimore** MD N/A 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral 505 Collins Ave. U.S.A. 21229 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 0 þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black "natural" 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Collections Bank of America years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Johnson James Mary Ε. Snow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Johnson(mother) 4411 Rokeby Rd., Baltimore, MD 21229 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Joseph Brown F/H And Crematory or other plage) 1 Burial 2 X Cremation 3 Removal from State 05/14/10 4 Donation 5 Other (Specify) Baltimore, MD Signature of Funeral Service Licensee ²² Name and Address of Facility NOSEDN H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21217 Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate Interval Between immediate Cause (Final Onset and Death cell Prolymphoblastic Physician/ disease or condition Medical resulting in death) Due to (or as a conseque ce of) Examiner 2 months dequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last burial attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death ed by the a 9 Unknown P.O. signed to Part II. **Other significant conditions** contributing to death but not resulting in the *u*nderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Records, cate has been sig page 2 should b Completed 1 Yes No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? this certificate Yes 2 Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ER/Outpatient 3 DOA မှ Director: After the 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completed filled in by in by 4 Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** nAL /Medical 4a. Facility Name (If not institution, give street and number) Examiner Columbia Howard <u> Howard County General Hospital</u> 8. Date of Birth (Month, Day, May 16, 9. Birthplace (State or Foreign Country) Finland . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** Hours 1 □ M 2**X** F Months Days 1920 89 001-14-3639 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10h County 28a-f show iner result be notified at 1 ☐ Yes 2√ No by Funeral Director Maryland Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 21044 United States items 23a 5400 Vantage Point Road HC424 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married "natural", or 1 ☐ Yes 2X No Specify: it of Health and Mental Hygiene. If item 27 is marked other than "natural", or or other traumatic event, I would all Event Specify: White 3 ₩ Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerical Assistant Library 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Peter Jaaskela Edith Leinonen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important; If Item 27 is any injury or other trae 1304 Hubner Avenue, Catonsville, Maryland 21228 Brooke E. Parr/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. May 12, 2010 Baltimore, Maryland 22. Name and Address of FacilitCremation Society of Maryland, Inc. Signature of Funeral Service License Amanda Heaston 299 Frederick Road, Baltimore, Marvland 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) KEUMONI **Physician** /Medical Que to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 | Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To of 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Division 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No filled in by the f 6 ☐ Could not be 3 □ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide e Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hou To the Fune completely fil

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

32. Registrar's Signature 31. Date filed (Month, Day, Year)

OU SVITE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARY th 11, 2010 DANIEL EMIL FRITZ Year 9:00P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Glynn Taft Assisted Living Catonsville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1 🕅 M 2 🗆 F Months 215-12-8816 DECEMBER 1997,1921 MaryTaha 88 Director Yrs. Usual Residence of Decedent of Health and Mental Hygiene. item 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 ☐ Yes 🕅 No Maryland Baltimore Catonsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 5741 Edmondson Avenue 21228 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces Yes 2 No ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WWII 1 ☐ Yes XX No Specify: Specify: 3 X Widowed 4 □ Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Manufacturing Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Emil Fritz Elsie Theil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole T Wilhelm Niece 9637 Sunset Drive Powell Ohio 43065 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Moreland Memorial Park May 15,2010 Donation 5 Other (Specify) Baltimore, Maryland nature of Funeral Se 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ MOINT Medical Due to (or consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Examin and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician a s the burial-Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death ed by the a g Unknown 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? page **Division of Vital** completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Tes 20 No မှ 4 Nursing Home 5 Residence 6 Other (Specif 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 No Investigation Accident 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one within 7 29b. Signature (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Box 68760

P.O. 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		201-1-1	partment of Health and	Mental Hygi	ene			
		1 - State Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg. No. 2010 1498				
Physic		Robert Leon Frock		2. Date of Death Month May	eath Day Year 2010 3. Time of Death 2:34P M			
Med Exam		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	Z:34F		
		Kline Hospice House	New Market		Frede	rick		
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 1 ☑ M 2 ☐ F 70 Yrs.	/) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y Aug. 11	(ear) 9. Birthpla Country	ce (State or Foreign		
Directo		Usual Residence of Decedent		Aug. 11	, 1939 Mary	land		
land show	호	10a. State 10b. County 10c. City, Town or	Location		100	. Inside City Limits		
Mary 28a-i	je	Maryland Frederick	Woodsbor			1 🗌 Yes 2 🔀 No		
flaryland 21215-UU36 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 11254 Creagerstown Rd.	10f. Zip Code 21798	10	g. Citizen of What Country USA	n		
eath v tems er mu	Fun	11. Marital Status 12. Was Decedent Ever in U.S. 13	3. Was Decedent of Hispanic Origin? (Sp.	pecify Yes or No-	14. Race - American	Indian,		
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rarylan should be fil and Mental is marked aumatic eve		Roscoe V. Frock Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Ma			lle Barnhart	(4)		
≥ ⊘ € ⊘ ₹			illing Address (Street and Number or Rui 54 Creagerstown Ro		dsboro, MD 2	·		
of Hear of Hear of Hear fitem		20a. Method of Disposition 20b. Place of Dis	position (Name of rematory or other place)		0c. Location - City or Town			
Saltimore, permit. Page 1 and Department of Hea mportant: If item any injury or othe nnce.		4 Donation 5 Other (Specify) Mt. Hop	e Cemetery 5/8/		Woodsboro, M	ND .		
Baltimor permit. Page 1 : Department of I Important: If its any injury or of once.		21. Signstuk (Ameral Service Lieffs & Carller	22. Name and Address of Facility Ha					
		23a. Part 1. Enter the disease, or complications that caused the death. Do not e	404 S. Main St. nter the mode of dying, such as cardiac		oro, MD 2179	pproximate		
Ph sician	,	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	colon ca	ncer	In	terval Between nset and Death		
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oor ertifica iding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy						
death ce	Physician/Me	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Da	ıy Year		
the de by the ached	hysi	9 Unknown						
s, F.O. BOX 00/10.	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the			
equire een si	eted					ly 4 🗌 Unknown		
e Cords, e law requires e has been sig ge 2 should b	Completed			24a. Was an autopsy performe		findings available letion of cause of		
an: Th tifficate tor, pa	Be Co	25. Was case referred to medical	26. Place of Death (Chec	1 ☐ Yes 1	No 1 Yes 2	No		
VILCII nysician nis certifi	P P	examiner? 1	ient 3 DOA Other: 4 Nursing H	ome 5 - Residence	ce 6 Other (Specify)	ospigouse		
ling Pl	ate:	27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time injury	work?	28d. Describe how	injury occurred	(
VISION or Attendir fler death. irector: Af	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Described detailed 28e. Place of Injury - At home, farm, \$	M 1 ☐ Yes 2 ☐ No	28f Location /Stree	et and Number or Rural Ro	ute Number		
talor, safter al Dire		4 Homicide determined building, etc. (Specify)		City or Town, S				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check (Check 2 Medical Examiner: On the basis of examination and/or inv	estigation, in my opinion, death occurred a	at the time, date and p	place, and due to the cause	(s) and manner stated.		
o the vithin 2 o the	ž	only one) 3 Cestifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of pertifier	, death occurred at the time, date and pla 29c. License number		ause(s) and manner as state d. Date signed (Month, Day			
F S F O		ANOHA MO	D 48184	+	5/5/10	, ,		
V		30. Name and address of person who completed cause of death (Item 23a) (Type	Print) 1 Hb -1	at Fal	erick, MD.	01701		
		31. Date filed (Month, Day, Year) 32. Registrar's Signature	501 W 1111 011	eei 1 (ede	MCK, MD.	2110		
Sta Regist		MAY 13 2010 Server S. Jane						
	_							

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Day LORRAINE V. GREEN 18:18p ^M MAY 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 3401 ROYCE AVENUE BALTIMORE 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F Months Days Hours (Month, Day, Yea Country) MARYLAND 81 Yrs Director 217-26-2981 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1XXYes 2 □ No MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3401 ROYCE AVENUE U.S.A. 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 XXIIIo
If Yes, Give
Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 XXNo Specify: Specify: BLACK 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) PACKER INDUSTRIAL 12th grade Be Marylahd 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည STANLEY HENRY VIRGINIA HENRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Hubbard/Daughter 8212 Scotts Level Rd., Pikesville, Md., 21208 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE NATIONAL 05-18-10 BALTIMORE, MARYLAND 21. Signature of Funeral Source Licensee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death CARDIOMYOPATH Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Examiner sician and burlal-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Tes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performed? 2 🗌 No Yes 2 No 1 Yes Division of Vital To the Hospital or Attending Physician: hours after death.

neral Director: After this certific
d filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes မူ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 24 hours Funeral Medical 1 🖰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and Atla of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2600 CIBERTY HEIGHTS AVE, BACTIMORE MD MORGAN MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 per md., g903,05/13/2010dhb

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month May Day 2010 Year DONNA 2 6:49 COLSON GREENBERG Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min. (Month, Day, Year) ay 16 1963 215-84-8988 **Director** 46 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Frederick Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho. 10b. County 10d. Inside City Limits Director Frederick 1 🗆 Yes 2 🖁 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6621 Jefferson Boulevard 21703 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 4^{College (1-4 or 5+)} Elementary/Seconday (0-12) data base network manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur J. Colson Sarah M. Cullop 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6621 Jefferson Blvd., Frederick, MD 21703 Ronald Greenberg (spouse) 20a. Method of Disposition
1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Crest Lawn Mem. ö Department of Important: If any injury or 5-6-10 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of FacilityHaight Funeral Home & Chapel Harch MO0764 P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) DISSEMINATED INTRAVASCULAR COACULATION Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-tranthat initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CARCINOMA GASTRIC Completed 1 Yes 2 No 3 Probably 4 Unknown CHEMOTHERAPY 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an nas l autopsy RADIATION Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours at Funeral D leted filled in Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nursus Practioner: To the basis of my kin, which is death of my kin, whi (Check within 2

DHMH 17 Rev 7/2009

State

Registrar

istrar's Signature

Eneur.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOOG7483

400 WEST SEVENTH STREET, MD 21701

29d. Date signed (Month. Day, Year)

05. 02. ZOID

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month George Herquet Raymond 2้ชี้10 8. 9:05 ам May Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Hospital Elkton Cecil If Under 1 Year If Under 24 Hrs Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Months Davs Hours Min. Director 435-48-4196 74 10/15/1936 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location the Maryland Director 10d. Inside City Limits ms 23a or 28a-f s must be notified Cecil Elkton 1 🗌 Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21921 28 Elk Chase Court USA ral", or items death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 2 No 72 hours after White 1 LYes 2 X No Specify 3 Widowed 4 X Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 Elementary/Seconday (0-12) within College (1-4 or 5+) unkn. 2 Truck Driver Transportation Be filed Maryland 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ Unkn. George Herquet should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Kevin Michael Beaudean/Nephew 42 Dixon Lane, Elkton, MD 21921 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crem. 5/12/2010 Woodbine, MD 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD Signature of Funeral Service Licensee Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate the sequence of the Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant
9 Unknown Month Dav Pregnant at time of death 5 Other (specify) Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performe certificate 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director. After this certifical completed filled in by the funeral director, 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one title of certifie 29c, License numbe 29d. Date signed (Month, Day, Year) ne and address of person who completed cause of death (Item 23a) (Type, Print)) (V 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Hill Viola 05 09 2010 11:15a^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Frankford Nursing Home Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days 1 🗆 M 2 😾 F Months Hours Director 212-42-0474 87 Usual Residence of Decedent 28a-f shov 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 XYes 2 ☐ No MD NA 10e, Street and Number 10g. Citizen of What Country? Funeral U.S.A. 21206 5009 Frankford Ave death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married þ 1 ☐ Yes 2 【XNo If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 ♥ Widowed 4 □ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Private Domestic Worker 10th grade na permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other i any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Grace Pynes James E. Dyson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Columbus Drive, Baltimore, Md 21215 Jerome Dyson-Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) On-Site 5/18/2010 Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West Baltimore, Md 21215 4300 Wabash Ave, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physiciani disease or condition resulting in death) Demention Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown jo Month Pregnant at time of death Day Year signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> 2 No 3 Probably 4 Unknown Emphysem a Completed 24a. Was an Were autopsy findings available prior to completion of cause of page 2 autopsy certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical 1. **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dead occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) 0 43386 5-11.10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) a. 1714 Eulew Mace Balknoor stancad 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 4 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20/C Medical 4a. Facility Name (if not institution, gi ve street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner stminster 8. Date of Birth (Month, Day 7. Age (In yrs. last birthday) If Under 24 Hrs 9. Birthplace (State or Foreign Funeral 1 M 2 F Yrs. Director Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Examiner must be notified at Director or 28a-f 1 Yes 2 No Stea 10e. Street and Numbe 10g. Citizen of What Country? 23a Funeral 21074 or items Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes Give . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Specify: White 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or MACEDON A CEMETER BESSEMER 21. Signature of Funeral Service Licensee YORKRD. MON'XTON MID 21111 - CREMATION STUCES-MORKER Evans tuncia 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure/List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final-Onset and _ Bilateral Physician/ preumow in disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami attending physician and for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 23e. Did tobacco use contribute to the cause of death? Completed by Nyponakemia 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 127/44 UNIT # 03-83-90 05/02/10 performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 08/ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗵 No 1 🔀 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA ANN 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Tes 2 Accident 3 Suicide Investigation **HUDSON, DOROTHY** 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier CHACKO, BINU Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 031660 1,5010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS K. GALVIN

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

istrar's Signature

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WESMINSTER MAULE

STUNEIL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ \mathbf{P}_{M} May Month 5:45 Joseph Mark Heimerl 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b City Town or Location of Death 4c. County of Death 108 Paradise Dr. Harford Havre de Grace 6. Sex 1 **X** M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Country)
New Jersey Months. Director 155-28-1317 70 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21078 108 Paradise Dr. USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married þ Specify White Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Department of Defence Elementary/Seconday (0-12) College (1-4 or 5+) Physicist ulth and Mental Hygien 27 is marked other the r traumatic event, the Be Department of Health and Mental H Important: If item 27 is marked oft any injury or other traumatic 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Heimerl Madelyn Kayden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Heimerl / wife 108 Paradise Dr, Havre de Grace, MD Baltimore, 20a. Method of Disposition
1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Darlington Cemetery 5/15/2010 Darlington, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Tarring-Cargo Funeral Home, P.A. 333 S. Parke St, Aberdeen, MD 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death rostate Immediate Cause (Final Physician/ Cancer disease or condition year Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Dav Year Pregnant at time of death 9 Unknown be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available 24a. Was an has autopsy prior to completion of cause of perform After this certificate 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury s after death. 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check within 2 To the 3 Certifying N rse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one nd title of certifi 29b. Signature 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item

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DHMH 17 Rev 7/2009

State Registrar O

31. Date filed (Month, Day, Year)

Orleans

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. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 20Î 8:050 RICHARD HOLLEY EDWARD Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charles Genesis of Waldorf Waldorf Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛂 M 2 🗆 F May 12, Year 925 Director 579-20-5135 84 DC Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Prince Georges Brandywine 1 Yes 2X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7630 Moores Rd. 20613 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian Armed Forces X Yes 2 1943-Yes, Give 1946 Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural". Specify: 3 Widowed 4 Divorced Year or Dates Black permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 10\text{th} \end{array}$ College (1-4 or 5+) Administrator Dept. of VA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Richard E. Holley Ethel Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brandywine, MD. 20613 Lois L. Holley - Wife 7630 Moores Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans 4 Donation 5 Other (Specify) 5-13-2010 Cheltenham, MD Signature of Funeral Service Licenses Marshall's Funeral Home of Maryland, Suitland, Md. 20746 4308 Suitland Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Carcinoma of Lung disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence or): Examir Hospital or Attending Physician: The law requires that the death certificate be execute s been signed by the attending physician and should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4 Pregnant 9 Unknown Pregnant at time of death Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Alzheimer's Disease 24a. Was an autopsy performed? Yes 2 1 No After this certificate has completed filled in by the funeral director, page 2 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Other: 4 🗵 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify, Hospital 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work?
1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending 2 Accident
3 Suicide Investigation after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 3 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who comp

Philip Wisotsky, 31. Date filed (Month, Day, Year)

12070 Old Line Center #207

eted cause of death (Item 23a) (Type, Print)

M.D.

D12906

5/12/2010

Waldorf, MD. 20602

State of Maryland / Department of Health and Mental Hygiene Amend Items 23aPtI,II,25,27,28a-f per me, g903,05/13/2010dhb Reg, No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death

Physician /Medical Examiner

Funeral

Director r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

within 72 hours after death with the Maryland Director Woodsboro 10e. Street and Number 10f. Zip Code 9942B Woodsboro Rd. by Funeral 21798 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2X No Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 secretary 17. Father's Name (First, Middle, Last) Be Mental I Pages 1 and 2 should be Charles E. Lamson ဂ Jane Grahm and is 19a. Informant's Name/Relationship (Type. Print) of Health of item 27 is <u>Kathryn Palmer/ daughter</u> 3030 Green Valley Rd. injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages Department of Important: If it any injury or or 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Peter's Cemetery: 4/21/2010 St 21. Signature of Funeral Service Lice Take 404 S. Main St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** bavra /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed Coagulopathy, Cirrhosis of liver 24a. Was an autopsy certificate performe 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1X Yes After this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1. Natural 2 Accident 5 ☐ Pending investigation Injury April 2010 Unknown 1 ☐ Yes 2 X No 24 hours after deatl Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Home 29a. Certifier Medical (Check only one) within 2. 29b. Signature and title of certifier 29c. License number 13/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10200 Coppermine Rd. trar's Sign ture Gene Ashe Woodsboro, MD 21798

32. Registrar's Sign

3. Time of Death Day Year 11:45A M Patricia Jane Huffer April 18 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 9942B Woodsboro Rd. Frederick Woodsboro 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2X F Months Days Hours Min. 340-22-9785 Sept. 6, 80 1929 Minnesota Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No Maryland Frederick 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry public schools 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ijamsville, MD 21754 20c. Location - City or Town, State Libertytown, MD 22. Name and Address of Facility Hartzler Funeral Home Woodsboro, MD 21798 Approximate Interval Between Onset and Death CERTIFICATION AFFRONED BY MEDICAL EXAMINER 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Subject fell. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 9942B Woodsboro Road, Woodsboro,MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 4-19-10

State

31. Date filed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7

1 - State Amend Item 25 per me,g903,05/13/2010dhb
Certificate of Death
Registrar Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $M_{\text{av}}^{\text{Month}}4$, 20^{2} Robert Roy Hottel, Jr. 0916 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, Year) | Feb | 26, 1936 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ★ M 2 □ F 74 578-48-9871 Washington, Director Yrs. DC Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director VA Loudoun Philomont 1 🗆 Yes 2 🎦 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20765 Watermill Road 20131 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Investor Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Roy Hottel, Sr. Hazel Nita Atkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20765 Watermill Road Philomont, VA Maria Hottel - Wife 20a. Method of Disposition
1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State injury or 4 ☐ Donation 5 ☐ Other (Specify) 5/10/10 Beaver Dam Farm Cem. Philomont, VA 21. Si natur of Funeral Service Licensee 22. Name and Address of Facility Hall Funeral Home ller P.O. Box 896 Purcellville, VA 20134 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Intracerebral Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions Examine if any, leading to immediate value. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death g 🗌 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown certificate has been si rector, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 🔀 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner?
1 Yes 2 1 No **Division of Vital** Be 26. Place of Death (Check only one) မြ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗽 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) D 46052 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Strend Berly MD 2001 Medical Parkway Canhapths, MD Beily Mo 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

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10-03582	
Deborah Harris	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		For State eqistrar Decedent's Name (First, Middle, Last) Certificate of Death Reg. No. 2. Date of Death 3. Time of Death									
Physician/ Medical Examiner		1. Decedent's Name (First, Midd Debra	D. Ha				ay Year	3. Time of Death 1310 hrs			
To the state of th		4a. Facility Name (if not institution Gwynns and 3912 Gwynns Falls Pa	n, give street and n arkway	umber)	41	Baltimore	Location of	Death		4c. County of Deat	n
Funeral Director		5. Social Security Number 214 86 6692	6. Sex	7. Age (In yrs. last t	birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min		MM/DD/YYYY) 9. Bir Forei 0 , 1963 Co	thplace (State or gn puntry) MD
my		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	wn or Locatio	n					10d. Inside City Limits
and show a	٦	MD	n/a		Balti	more					1 Yes 2 No
h the Maryland 3a or 28a-f show any otified at once.	Director	10e. Street and Number Gwynns Fall	3912 s Pkwy.			10f. Zip Code 21216			10g.	Citizen of What Cou USA	ntry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a nor 28a-f sho injury or other traumante event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 MM 3 Widowed 4 Div		2 💂 No	If Yes	Decedent of Hisp s, specify Cuban, res 2 X No	Mexican, P			White, etc.	ican Indian, Black,
ours aft atural' camine	d b	15. Decedent's Education (Special	or Dates:		a. Decedent's	Usual Occupation	on (Give kir	nd of work	done 16	Speci Blac Sb. Kind of Business/	
136 hin 72 h e. than "n edical Es	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		nt Cle		se retired)	H	H&B Disc	ount Store
5-00 iled wit Hygien I other		17. Father's Name (First, Middle,							st, Middle, Maid		
ID 21215-0036 : should be filed within 72 and Mental Hygiene. ?7 is marked other than matic event, the Medical	To Be	Claude S. H	hip (Type, Print)	T	19b. Mailing A	Address (Street	and Numbe	er or Rural	. Yanc	r City or Town State	, Zip Code)
MD and 2 sho salth and 27 is raumati		Tynisha L. H	arris (d	daughter) 391	2 Gwyn:	ns Fa	alls	Pkwy	Balto, Mo	3. 21216
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than nijury or other traumante event, the Medical		1 X Burial 2 Cremation 4 Deprivation 5 Other Sp	pecify:	rom State crem	nitory or othe nity	r place) Cemete:	ry l	May]	15,201	.0 Balto	,Md.
Balt permit Depart Impor injury		21. Surfature of Funeral Service	:7/	Charee	22 Nai	Tvin B	of Facility SCI	ruggs	Fun	eral Hor	
Physician /Medical	1	23a. Part I. Enter the disease, or failure. List only one cause	complications that on each line.	caused the death. Do	not enter the	mode of dying, s	such as card	diac or resp	oiratory arrest,	shock, or heart	21213 Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Acquir Due to (or as	ed immuno	defici	ency sy	ndrome	e & p	resumed	l sepsis	Death
	5	Sequentially list conditions, is any, reading to immediate		renous dru	g abus	е					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	С.	a consequence of):							
ecuted and - transit	Ex	events resulting in death) Last	ď.	,							
760, icate be exe physician a	Medical	UNPENDED	X AMENDED	PI line a a, per ME	-bg03 ²⁷	5/13/10	E rg 904	4 6/18			
68760, certificate be nding physici se as the buri		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	e 1 Live b		· —	death 3	Ectopic p	regnancy		23d. Date of delivery Month	v Day Year
Box 687 death certifi the attending ed for use as t	Physician	1 Yes 2 V No 9 Unk	nown 9 Unkn	nant at time of death own	5 Othe	r (Specify)					
P.O.		Part II. Other significant conditi	ons contributing to	o death but not result	ing in the und	lerlying cause giv	en in Part l	l.		co use contribute to	the cause of death?
of Vital Records, P og Physician: The law requires t ther this certificate has been sign meral director, page 2 should be	Completed by								24a. Was an autopsy		topsy findings available on the completion of cause of
Recc The lavicate har	ĕ							_	performed		
Vital Revision: The his certificate director, page	a	25. Was case referred to medical examiner?	Hospital:	Inpatient 2 ER/	Outpatient 3		of Death (Cl	heck only o Jursina Hor		idence 6 🗸 Other	Scope
ion of V tending Phy eath. tor: After thi the funeral d	라	1 Yes 2 No 27. Manner of Death	28a. Date		. Time of Inju					injury occurred	. Scerie
Division tal or Attendir rs after death.	catio	1 Natural 5 Pend Pend Inves	ing tigation		ftt		es 2 No				
Divisi pital or At ours after d neral Direct filled in by	Certification:		not be mined (Specify)	e of Injury - At home,	iaini, street,	ractory, office but	ildirig, etc.		or Town, State)		ral Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	dical	one) 2 Medical Exam	miner: On the basis	st of my knowledge, do of examination and/or tated.							
H 3 H 3	ĕ	29b Signature and title of cortified	407/	1 3000	7	29c. License O.C.M				d. Date signed (Mor	nth, Day, Year)
	-	30. Name and address of person	who completed cause	se of death (Item 23a))	J.O.IVI			INI	lay 10, 2010	
		Victor Weedn MD JD	Assistant Me	dical Examiner		n Street, Ba	ltimore,	MD 2120	01		
Sta Regist	ate rar	31. Date filed (Months Day) (e.g.)	3 2010 32. Rg	distrar's Signature	Spa	Kel					

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (U) Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Mav Physician/ 2010 5:30p Thomas Phillip Johnson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Rock Glen Nursing & Rehab Center Baltimore 8. Date of Birth (Month, Day, Year) May 23, 1925 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs Funeral 1 🔀 M 2 🗆 F Days Maryland Director 216-18-4716 84 Usual Residence of Decedent show 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Baltimore Maryland N/A 10e. Street and Number 10g. Citizen of What Country? Funeral United States 10 N. Rock Glen Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 14. Race - American Indian, 1 X Yes 2 No 1951-If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 1953 3 Widowed 4 K Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Traffic Division State Road Commission Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည Phillip Henry Johnson Edna Α. Mav 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Page 1 and 2 1840 Darrich Drive, Parkville, Audrey M. Hopwood/ Sister Maryland 21234 item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ò ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Department of Important: If any injury or 4 Donation 5 Other (Specify) Metro Crematory, Inc. 5/12/2010 Baltimore, Maryland Signature of Funeral Service Liconsee Amanda Heaston 22. Name and Address of Facilit Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph, i i n disease or condition resulting in death) 2 Day Medical consequence of Examiner Sequentially list conditions, Examine Due to for as a ponsequence of ff any, leading to in medicause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Pregnant at time of death 2 No been signed by the should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by I 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No After this certificate has autopsy 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 2 2x No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 2 Accident
3 Suicide
4 Homicide after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) Rd. Caforsville 100 Registra s Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 03/16/1943 Hours 1 □ M 2 🛣 F Months Director 67 533-42-1659 OK Usual Residence of Deceden 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f shore event, the Mecical Examiner must be notified at 10d. Inside City Limits Director MD Howard Dayton 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13516 Orion Drive 21036 USA permit. Page 1 and 2 should be filed within 72 hours after death of Department of Health and Mental Hygiene. Important I if item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify: 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname)
Pauline Marie Hudson 17. Father's Name (First, Middle, Last) Sanders Edwin Leroy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6575 Twilight Glow Drive, Sykesville, MD 21784 Jessie F. Sanders-Roman/Sister 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 5/13/2010 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crem. Woodbine, MD 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 21. Signature of Funeral Service Lice 💎 Dorota, Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Cor disease or condition resulting in death) Medical D to (or as a consequence of): **Examiner** 8 days Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence of: Exami and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 the as IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death the 9 Unknown P.O. I signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? within 24 hours a er death.

To the Funeral Director. After this certificate I completed filled by the funeral director, page 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 Z No Investigation 05-01-2010 1.00 all down 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Home 13514 Orion Dr DayTon, mi the Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 9-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene St Baltimore 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗍 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AW50N Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death 2052 Griffis Avenue Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F Months Days Hours Min Director 213-52-0301 Baltimore, MD 63 Usual Residence of Decedent 10b. County 10a, State should be filed within 72 hours after death with the Maryland and Mental Hygiene. iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore 1 XYes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? United States Funeral 2052 Griffis Avenue 21230 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces' Black, White, etc. Completed by 1 Never Married 2 🔀 Married X Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", If Yes, Give WHITE 3 Widowed 4 Divorced Specify Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other transmit. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Driver Vending Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gilbert M. Klinedinst Catherine L. Warren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2052 Griffis Ave. Baltimore, MD 21230 Barbara L. Klinedinst- Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) tlantic Crematory,LLC 5-8-2010 Glen Burnie, MD Signature of Funeral Service Lio 22. Name and Address of Facility Am rose Funeral Home of Lans own 2719 Hammonds Ferry Road Lansdowne, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a co Examine Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Day Year signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signated should be 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? ဂ 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date ø Certificate: iniurv 28b. Time of 28c. Injury at 28d. Bescribe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation after deat Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) City or Town, State) 24 hours a Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 7 Certifying Nurse Practioner: To the best of my knowled causale) and marrier as stated 29b. Signature and title of certiller 30. Name and address of person w completed cause of death (Item 23a) (Typ 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 5 per fh. g903.05/3/2010dhb

Amend Items 28a-f per me. g903.05/13/2010dhb 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Allen Eugene Lee Day 2010 Medical a 4a. Facilify Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death St. Joseph's Hospital Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1**火** M 2 □ F Months Days Hours (Month, Day, Year, 219-42-9107 Director 65 9 1945 Marvland Usual Residence of Decedent or 28a-f show 10a. State 10b. County be notified at Director 10c. City. Town or Location 10d. Inside City Limits MD Baltimore Essex 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3228 Miller Avenue Apt. C 21220 USA Examiner must items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. "natural", or 1 Never Married 2XXMarried þ 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed id Mental Hygiene. marked other than "natur matic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8th Grade Carpenter Self-Employed permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert Lee Mary M. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3228 Miller Avenue Apt. C Essex, MD 21220 Sharon Lee/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Carmel Cemetery 4/24/10 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mt. 22. Name and Address of Facility Chatman-Harris Funeral Home Signature of Funeral Service Licenses ullen 4210 Belair Road Baltimore, 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical as a consequence of Examiner orla VEDICA EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine use as the burial-tran been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Completed by Physician/Medical or Attending Physician: The law requires that the death certificate be Dm IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Leustom 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopsy performed' 2 No Yes 2 No 1 Yes 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? 1 X Yes Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury 1XX Natural 5 Pending work? 1 ☐ Yes 2 🕶 No 2 Accident
3 Suicide
4 Homicide Investigation after death Director: / 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital 24 hours a Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practice on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 only one 29b. Signatur 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State Amend Item 2	State of Ma 24a,26 per v	aryland, verb.,	/ Depa g903 Ceri	rtment of L 05/13/20 dificate of L	lealth 10dh l Death	and M b	ental Hy	giene Reg. No.	2010	14996
	Physicia Medic		1. Decedent's Name (First, Middle, L.			e				2. Date of Death Month 5 - Bay Year 3. 3 Time of Death 3. 3 A U			
-	4a. Facility Name (If not institution, give street and numb 3934 Edmondson Ave.					4b. City, Town, or Location of De Baltimore				h		4c. County of Death N/A	
	Funeral Director		5. Social Security Number 6.		(In yrs. last I	<i>birthd</i> ay) , Yrs.	If Under 1 Year Months Days		24 Hrs.	8. Date of Birt 1 0 7 2 7 a)	h 195	0 g. Bir Ma	thplace (State or Foreign
yland	f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County		10c. City, To								10d. Inside City Limits
th the Mar	3a or 28a t be notifi	al Director	MD N/A 10e. Street and Number		<u> </u>	Balti	10f. Zip Code		<u>,</u>		0	zen of What Co	1 ☐XYes 2 ☐ No
36 fter death wi	Department of Health and Mental Hygiene. Important: yor items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur	3934 Edmondson 11. Marital Status 1 □ Never Married 2 🕱 Married	12. Was Decedent Ev Armed Forces?		lf	/as Decedent of His Yes, specify Cubar	n, Mexica	n, Puerto R	ify Yes or No- lican, etc.)	1	J.S.A. 14. Race - Ame Black, Whit	e, etc.
21215-0036 within 72 hours after	an "natural" Medical Ex	Completed	3 Widowed 4 Divorced 15. Decedent's Specify only highest (Specify only highest (0-12)	Year or Dates. Education		6a. Decede	ent's Usual Occupa ind of work done d NOT use retired)	ation		g	16ь. Кіг Ва І		e CIty
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Baltimore, permit. Page 1 and	Department Important: any injury o once.		4 Donation 5 Other (Spe	cify)	Gari	, 22 .Te	n Fores	s of Facili	itown	3/10 Jr. F	uner	timor	me
# # # # # # # # # # # # # # # # # # #		- 29	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between										
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S///6	physician and the burial-transIt	dical Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	nce of):							<u></u>		
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Division of Vital Records,	ate has bee page 2 sho	Completed by Physician/M								24a. Was autop perfo	osv	prior to	rtopsy findings available completion of cause of s 2 □ No
if Vital	s certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2□ER	/Outpatient	_ Othe		ath <i>(Check</i>		tence 6	Other (Spec	rify)
on of	ath. r: After thi e funeral c	icate: T	27. Manner of Dea n 1 Natural 5 Pending 2 Accident Investigati	28a. Date of injur (Month, Day,	y 28	b. Time of injury	28c. Injury work	28c. Injury at work? 28d. Describe how injury occurred					
Division al or Attendir	s after de	l Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ry - At home . (Specify)	, farm, stre	et, factory, office		2	8f. Location (S City or Tow		l Number or Ru	ral Route Number,
D the Hospital	nin 24 hour t he Funer a npleted fill	Medical	(Check 2 Medical Exa only one) 3 Certifying No	nysician: To the best of r miner: On the basis of ex urse Practioner: To the b	amination an	nd/or investi	gation, in my opinio	n, death o	ccurred at t	the time, date a	nd place,	and due to the	cause(s) and manner stated.
7 96	Vitt To t		29b. Signature and title of certifier	libao			29c. License	number	1267	,	29d. Date	e signed <i>(Mont</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Kayen Cousing—Binum Bar Linden AV Balt Mo. 2120								201					
0	Stat Registra		31. Date filed (Month, Day, Year) MAY 13	2010 32. Registra	r's Signature	1. 4	arkel						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Ronald Raymond Lough, II 5:15 A M 2010 Medical May 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Baltimore 1331 Riverwood Way If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months 47 220-82-7910 Director 26 1963 Maryland Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director Anne Arundel **Baltimore** Maryland 1 🗆 Yes 2 No 10e. Street and Number 10g. Citizen of What Country?
United States 10f. Zip Code 21226 Funeral 1331 Riverwood Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedo... Armed Forces**Y** 1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give Maryland 21215-0036 White 1 Yes 2 No Specify 3 Divorced 4 Divorced Specify. Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ္ Carolyn Patricia Granger Ronald R. Lough, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1331 Riverwood Way, Baltimore, MD 21226 19a. Informant's Name/Relationship (Type, Print) Linda L. Lough - Wife Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Meadowing deter place) X Buri ☐ Cremation 3 ☐ Removal from State on 5 Other (Specify) 5-15-2010 Elkridge, MD 4 Don 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Aortic Physician/ disease or condition resulting in death) mediate Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Completed by Physician/Medical Examiner Due to (or as a consequence of): ed by the attending physician and detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown g Unknown P.O. I s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? disorder 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 has To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 4 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0058206 May 10, 2010 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 Gerpe Kd. Catonsville, MD 21228.

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 110,2010 ay RUTH KATHERINE LOCKARD 4:45P Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Dove House Westminster 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 5. Social Security No. 215–01–2005 1 □ M 2**XX**F Days Hours JAN 11 . 1918 Marviland Director Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 🖔 No Maryland Carroll Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 4942 Grave Run Road 21102 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2XX No Specify: If Yes, Give Year or Dates Specify: Completed 3XX Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Crossing Guard 12 Baltimore City permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Joseph Zimmerer Katherine Rebecca Lurz 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis Calvin Lockard Jr Son 4942 Grave Run Road Manchester Maryland 21102 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1💢 Burial 2 🗌 Cremation 3 🗌 Removal from State Parkwood Cemetery May 13, 2010 Baltimore, Maryland Donation 5 Other (Specify) gnature of Funeral S 22. Name and Address of Facility Mitchell—Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Durantia Dementia Dementia Durantia Durantia Durantia Dementia Dem Physician, disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of, or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Dav Year ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse, Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D 0026575 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar DAVID J HARTIG, MD

31. Date filed (Month.

10155 YORK RD STE 200

32. Registrar's Signature

COCKEYSVILLE MD

21030

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20a-c&22perFH,G904,6/16/2010,WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician Year 05 M Walter C. Lambie 15 2010 AY /Medical 4a. Eacility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MORE CSPITAL P N/A GNES ALT If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 9, 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 6 Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1952 1 → M 2 □ F Months 214-58-6160 58 **Director** Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show s 23a or 28a-f shorning be notified at Director MD N/A 1√∏Yes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1925 Ramsay Street 21223 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23: any Injury or other traumatic event, Ithe Medical Eventual and Injury or other traumatic event. by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White Specify: Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Grave Digger Funeral Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lloyd L. Lambie, Sr. Theoda M. Hissey ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Neva Lambie - Sister 1925 Ramsay Street, Baltimore, MD 21223 20a Method of Disposition
1 □ Burial 2 ★ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltymore Crematory

Loudon Park 20c. Location - City or Town, State Date 5/26/10 4 □ Dorlation o □ Other (Specify) unknown 22. Name and Address of Facility Ambras 20 Fundra Ave Journal Rank Funeral Home 3620 Wilkens Ave Raftimore William Spring Rd., Arbutus, Hu mD Signature of turn ral Service Landisee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Adult Respiratory **Physician** /Medical Due to (or as a consequence Examiner Sepsis month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Pregnant at time of death ☐Yes 2 ☐No 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen : 24a Was an within 24 hours after death.

To the Funeral Director: After this certificate has loompletely filled in by the funeral director, page 2 s autopsy rmed? 2 □ No e 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1□Yes 2☑No ဥ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death
1 ☑ Natural
2 ☑ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 ☐ Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital of 24 hours at Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D41843 2010 Wal 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21229 Boutmore tue

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 13 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 2**01**0 12:29 pM DOROTHY LAWSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges 7903 Green St Clinton Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Min. 1 M 2 K F Months Hours June 1, 1940 DC 578-52-8481 69 Director Usual Residence of Decedent ural", or items 23a or 28a-f shov I Exaπiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2 No Clinton MD Prince Georges 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20735 USA 7903 Green St. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Completed 3 Widowed 4 Divorced White Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Equitable Life Ins. Co. Executive Secretary yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy F. Fox Harry J. Beckert injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 7903 Green St. Donald Lawson - Husband Clinton, MD. 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🗵 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 5-11-2010 Alexandria, VA. Signature of Funeral Service Licensee Marshall so Fameral Home of Maryland, Inc. Suitland, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final .Physician/ Chronic Obstructive Pulmonary Disease disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Lung Mass Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) physician and s the burial-trans Diverticulitis that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 2 🔀 No 9 Unknown been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? this certificate has autopsy performed? 1 Ves 2 No 1 Yes 2X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 K No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of

4 State Registrar

Medical

29a. Certifier

(Check

2 □

Manoj Mathur, MD

31. Date filed (Month, Day, Year)
NAY 13 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

110 Hospital Rd. Suite 305

32. Registrar's Signature

🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

0

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month,

Prince Frederick, MD 20678